

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Haymen

RECEIVED

MAILED 1923

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *2*Registration District No. *1004**Alphonsus Hospital St.*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

*40968*Registered No. *29*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb 3 - 1923

(Month)

(Day)

(Year)

7. AGE

Still Born

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Boise Idaho.

10. NAME OF FATHER

H. Haymen

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Sylvia Walpert

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm McBratney

(Address)

Boise, Idaho.

15.

Filed *Feb. 3* 19 *23**R. N. Prady*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

189B

16. DATE OF DEATH

Feb - 3 - 1923

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *February 3, 1923*, to *February 3, 1923* that I last saw h. *alive* on *Feb 3, 1923*, and that death occurred on the date stated above, at *9 P.M.*

The CAUSE OF DEATH* was as follows:

Toxicemia of pregnancy and conpiment (Stillbirth)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Toxic nephritis of pregnancy

(Duration) Yrs. mos. ds.

(Signed)

L. R. McCall

M. D.

7/3 1923 (Address) *Boise, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Jewish Cemetery

DATE OF BURIAL

7/3 1923

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 41177**
Registered No. **65**

1. PLACE OF DEATH

County of **Ada**City of **Boise**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **2**Primary Registration District No. **1004**(No. **1915 Resque** St.)

2. FULL NAME

Infant Alexander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**M****White****Single**
(Write the word.)

6. DATE OF BIRTH

March 29 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

W. W. Alexander

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Caroline Bittes

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. W. Alexander

(Address)

1915 Resque

15.

Filed

Mar 30 19 23**R. N. Pratt**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 29 19 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 29 19 23 to Mar 29 19 23
that I last saw him alive on **Mar 29 19 23**and that death occurred on the date stated above, at **10** M.

The CAUSE OF DEATH was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. L. Dutton

M. D.

3/30/23 (Address) **Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Marion Hill Cemetery

DATE OF BURIAL

Mar 29 19 23

20. UNDERTAKER

Summers & Krebs

ADDRESS

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, ~~who are~~ engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

S 41197 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH **Bureau of Vital Statistics**
 Registration District No. **28**
 County of **Bannock** Primary Registration District No. **2141** File No. **28**
 City of **Pocatello** (No. **610 S. J.** St.) Registered No. **4022**
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME **Mary M. Bennett**
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE MARRIED, WIDOWED OR DIVORCED **Single**
 (Write the word.)

6. DATE OF BIRTH **Feb 8 - 1923**
 (Month) (Day) (Year)

7. AGE **Stille Born** IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Pocatello**
 (State or Country)

10. NAME OF FATHER **Richard Bennett**

11. BIRTHPLACE OF FATHER **N. Y.**
 (State or Country)

12. MAIDEN NAME OF MOTHER **Ada M. Wheeler**

13. BIRTHPLACE OF MOTHER **Idaho**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) **Richard Bennett**
 (Address) **Pocatello Id**

15. Filled **2/8** 19**23**
J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Feb 8** 19**23**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb 7 1923** to **Feb 8 1923**
 that I last saw her alive on **Feb 8 1923**
 and that death occurred on the date stated above, at **8:30 AM**

The CAUSE OF DEATH* was as follows:

Injured in childbirth -

(Duration) Yrs. mos. ds.
 Contributory (Secondary) **Breach Delivery**

(Duration) yrs. mos. ds.
 (Signed) **J. F. Miller** M. D.

Feb 8 1923 (Address) **Pocatello Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Dukon** DATE OF BURIAL **Feb 8 1923**

20. UNDERTAKER **Schumacher** ADDRESS **Pocatello**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 20 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Bea Gape* RECEIVED
 County of *Bea Gape* MAR 18 1923
 City of *Montpelier* BUREAU OF VITAL STATISTICS
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Sizemore

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **41212**
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Infant*
 (Write the word.)

6. DATE OF BIRTH *1 18 1923*
 (Month) (Day) (Year)

7. AGE *Stillborn* IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Georgetown

10. NAME OF FATHER

Ran Sizemore

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Kathryn Beckman

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. P. Galtier
Montpelier

15. Filed *3-1-23* 19 *23*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *1 18 1923*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *1-18 1923* to *1-18 1923*
 that I last saw him *Stillborn* alive on *19*
 and that death occurred on the date stated above, at _____ M.
 The CAUSE OF DEATH was as follows: *Unknown*
Stillborn

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *J. P. Galtier* M. D.

1-18 1923 (Address) *Montpelier*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Georgetown Id *1-18 1923*

20. UNDERTAKER

ADDRESS

Idaho Hosp Supply *Georgetown*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

22

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 21 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

S 41616
28State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____

County of Bannock Primary Registration District No. 2161City of Pocatello (No. St. Anthony Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant YoungFile No. 28Registered No. 4044

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDInfant
(Write the word.)

6. DATE OF BIRTH

March 23 1923
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Pocatello Idaho

10. NAME OF FATHER

W. H. Young

11. BIRTHPLACE OF FATHER

(State or Country) North Carolina

12. MAIDEN NAME OF MOTHER

Lollie Day

13. BIRTHPLACE OF MOTHER

(State or Country) Draper Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Young

(Address)

Pocatello Ida.

15.

Filed

3/25-1923Local Registrar J. P. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 23 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 23 1923 to same 1923that I last saw her alive on Stillborn 1923and that death occurred on the date stated above, at 3:30 M.

The CAUSE OF DEATH was as follows:

Still born
mother having influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3/27-1923

(Address)

Dr. J. H. Hewand M. D.
Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death St. Anthony Hospital In the State Idaho yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Cem

DATE OF BURIAL

Mar 25 1923

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41668

Registered No.....

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

mal *subit* (Write the word.)

 (Month) (Day) (Year)

7. AGE 34 years 10 mos. 15 da.

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

(State or Country) Norfolk, Va.

10. NAME OF FATHER Lloyd Dickman

11. BIRTHPLACE
OF FATHER
(State or Country) *Nampan. Ill.*

12. MAIDEN NAME
OF MOTHER *Phal Tongate*

13. BIRTHPLACE
OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lida C. Drexler
(Address) 1 Caldwell B1

15. Filed May 4 1923 Frank Gralik
Local Registrar

16. DATE OF DEATH

_____ April 11 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 10 1973, to Apr. 11 1973
 that I last saw h..... alive on..... 19.....
 and that death occurred on the date stated above, at..... M.
 The CAUSE OF DEATH* was as follows:

Pressure on card during _____
(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory.....
(Secondary).....
..... (Duration) yrs. mos. ds.

(Signed) Mallen Greenway, M. D.
4-11-1929 (Address) Baird Idaho

***State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
<i>New York City</i>	<i>Feb 13 1933</i>

20. UNDERTAKER	ADDRESS
1138	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

South Boise
Infant Wees

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

May 27 1923
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.IF LESS than 1 day
how many mos. yrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Joe Shepherd

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Lulu Wees

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Allen Greenway

(Address)

Boise Idaho

15.

Filed

5/28 1923R. H. Pratt
Local Registrar

RECEIVED

JUN 4 1923

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8
Registration District No. 2008 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41871
Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 27 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 27 1923, to May 27 1923
that I last saw him alive on May 27 1923and that death occurred on the date stated above, at 19 M.
The CAUSE OF DEATH* was as follows:Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. Allen Greenway M. D.May 27 1923(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery5/28 1923

20. UNDERTAKER

ADDRESS

Wm. E. BrakleyBoise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

Baumoc

County of Pocahontas

City of Pocahontas

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

MAY 1 1923

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

City of Pocahontas

2. FULL NAME

Richardson

S 41891

28

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.) Single

6. DATE OF BIRTH

April 7 1923

7. AGE

Still Born

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House

9. BIRTHPLACE

(State or Country)

Pocahontas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

4/9 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 7 1923

17. HEREBY CERTIFY, That I attended deceased from

April 7 1923, to April 7 1923, that I last saw him alive on April 7 1923, and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory (Secondary) Syphilis.

(Duration) yrs. mos. ds.

(Signed) J. H. Thompson M. D.

(Address) Pocahontas, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

New Cemetery

20. UNDERTAKER

M. H. Macker

DATE OF BURIAL

4/9 1923

ADDRESS

Pocahontas

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

17

RECEIVED
MAY 12 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41945
Registered No. 13

1. PLACE OF DEATH

County of Bannock Registration District No. 23
City of Idaho Falls Secondary Registration District No. 2150
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Feb 9 1923
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

Louis C Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Alma M Seybold

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L C Anderson
Idaho Falls, Ida

15.

Filed

Mar 6 1923 Wm
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 9 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1923, to Feb 9 1923that I last saw him alive on Jan 25 1923and that death occurred on the date stated above, at 11 PM

The CAUSE OF DEATH* was as follows:

Peripneumonia
born dead

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Cline

M. D.

Feb 10 1923 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Ship

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls, Ida2-10-1923

20. UNDERTAKER

ADDRESS

Edith WoodleyIdaho FallsDr Cline

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of **FREMONT**City of **ASHTON**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STILL BORN? CORDINGLEY

CERTIFICATE OF DEATH

Registration District No. **102**Primary Registration District No. **6**

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 42005**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **FEMALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

MAY 16th 1923

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

ASHTON IDAHO

10. NAME OF FATHER

WARREN CORDINGLEY

11. BIRTHPLACE OF FATHER

(State or Country)

UTAH

12. MAIDEN NAME OF MOTHER

ETHEL DORNEY

13. BIRTHPLACE OF MOTHER

(State or Country)

UTAH.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

WARREN CORDINGLEY

(Informant)

(Address) **ASHTON IDAHO**

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

MAY**16****23**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **E. L. Hargis** M. D.1923 (Address) **Ashton Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

ASHTON IDAHO

DATE OF BURIAL

5/16/23

20. UNDERTAKER

LEWIS KISER

ADDRESS

ASHTON IDAHO.

2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

213

MARGIN RESERVED FOR BINDING

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED

JUN 9 1923 CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Bozeman Registration District No. 90
City of Crofton Primary Registration District No. 2168
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe Vokhies Jr.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42361
Registered No. 25

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Baby
(Write the word.)

6. DATE OF BIRTH June 10 1923
(Month) (Day) (Year)

7. AGE Steelborn IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Crofton Idaho

10. NAME OF FATHER

Joe M Vokhies (nr)

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Celia Owens 43

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joe M Vokhies Jr.
Crofton Idaho

15.

Filed

July 1 1923

J M Vokhies
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 9 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth
_____ 191 _____

that I last saw him _____ alive on _____ 191 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

In hospital state of decaying at birth - Disposed of placenta. Mother had 2 children.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. M. Vokhies M. D.
6/10 1923 (Address) Crofton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Crofton Idaho June 11 1923

20. UNDERTAKER

ADDRESS

V. A. Schaefer Crofton

2

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

227

RECEIVED

JUN 25 1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

State Registration District No.

(No.)

St.)

Registered No.

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. 42408

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

Yrs. Mos. ds.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

6-10-23

19

23

Ray H. Hish

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19.....

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N.B.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Yofons

RECEIVED

AUG 5 1923

BUREAU OF VITAL STATISTICS

Registration District No. 8Registration District No. 2008(No. New Natatorium St.)

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. S 42609Local Registrar's No. 1723

If death occurs in a hospital, institution or home, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

F. Spanish Single
(Write the word)

6. DATE OF BIRTH

July - 18 - 1923
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Boise, Idaho.

10. NAME OF

Father Geo Yofons

11. BIRTHPLACE

OF FATHER (State or Country) Mich

12. MAIDEN NAME

OF MOTHER Mary Stanko

13. BIRTHPLACE

OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm McBratney(Address) Boise, Idaho.

15.

Filed July 19 1923 R.H. Peck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 18 - 1923.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 18, 1923. to 19,
that I last saw h. alive on 19,
and that death occurred on the date stated above, at N.

The CAUSE OF DEATH* was as follows:

Still birth
(unknown cause)
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Harold W. Stank M. D.
7/19/1923 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents).

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or

usual residence Don't know

19. PLACE OF BURIAL OR REMOVAL

County Cemetery DATE OF BURIAL 7/19/1923

20. UNDERTAKER

Wm McBratney ADDRESS Boise, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

24

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 43039**

1. PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 410 State Idaho St.)

Registered No. 178

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth L. Partridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Sept 5 1923
(Month) (Day) (Year)

7. AGE Seven IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. da.

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Boone Iowa
(State or Country)

10. NAME OF FATHER W. A. Partridge

11. BIRTHPLACE OF FATHER Id.
(State or Country)

12. MAIDEN NAME OF MOTHER Neena O. Roberts

13. BIRTHPLACE OF MOTHER Kan.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. A. Partridge
(Address) 2517 Heron St.

15. Sept 6 1923 Filed R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH unknown 19 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/5 1923 to 9/5 1923
that I last saw him alive on at no time
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows: unknown

Unknown
Body had been dead about 10 days. Died in utero.
(Duration) Yes mos. ds.
Contributing (Secondary) severe peritonitis
(Duration) Yes mos. ds.
(Signed) W. A. Partridge M. D.
9/6 1923 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence Boone Iowa

19. PLACE OF BURIAL OR REMOVAL Woods Hill Cemetery DATE OF BURIAL 9/7 1923

20. UNDERTAKER Schuber & Widenfaden ADDRESS Boone

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1. PLACE OF DEATH

County of AdaCity of Barber

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
OCT 4 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8Primary Registration District No. 2008

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. S 43054
Registered No. 2008-50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Sept 201923R. N. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1923
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1923, to 10that I last saw him alive on Sept 20 1923and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Premature birth
due to injury to mother
in a fall

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed) Ch. Parker

M. D.

19.....

(Address) 303 Melody Pl.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs..... mos..... days. In the State yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Middleton Cem.Sept 20 1923

20. UNDERTAKER

ADDRESS

Summers & Co.Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

263

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

U.S.

Registration District No.

96

County of

Lewiston

BUREAU OF

Primary Registration District No.

1009

City of

Lewiston

STATE OF

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Schmidt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

write the word

6. DATE OF BIRTH

Sept. 11, 1923

(Month)

(Day)

(Year)

7. AGE

still born

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Schmidt

11. BIRTHPLACE OF FATHER

(State or Country)

Mont

12. MAIDEN NAME OF MOTHER

Elizabeth Hartman

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Frank Schmidt
Lewiston Idaho

15.

Filed

Oct - 8

1923

Marion E. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 10, 1923

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 10, 1923 to Sept. 10, 1923

that I last saw him alive on Sept. 10, 1923

and that death occurred on the date stated above, at 10:45 PM

The CAUSE OF DEATH* was as follows:

Premature infant
(Cause unknown)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. B. Clark
Sept 12, 1923 (Address) Lewiston Idaho

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho

9-12-1923

20. UNDERTAKER

ADDRESS

Cassell & Co

Lewiston Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 28Primary Registration District No. 2161(No. 604, M. 10th ave St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 43926Local Registrar's No. 426

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Single

6. DATE OF BIRTH

Dec. 11 1923
(Month) (Day) (Year)

7. AGE

Still birth
Yrs. Mos. ds.IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Pocatello, Ida.

10. NAME OF FATHER

Jac. Paletti Dec 12 1923

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Josephine Devico

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jac. Paletti
(Address) Pocatello, Ida.

15.

Filed Dec 12 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 11 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Severe hemorrhage of mother
Still birth Dec 10-23
57 yrs.
1 day
dec.
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1923 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or
usual residencePocatello, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem. Pocatello Dec 12 1923

20. UNDERTAKER

ADDRESS

McKean and Co. Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)**. For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

1. PLACE OF DEATH

County of Boary Lake
City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 52
County Registration District No. 2136
BUREAU OF VITAL STATISTICS
(Not named) Baby WalkerState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. S 43944
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant
(Write the word:)6. DATE OF BIRTH Sept 14th 1923
(Month) (Day) (Year)7. AGE Steel-Born IF LESS than 1 day
how many _____ hrs.
Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE Montpelier Ida
(State or Country)10. NAME OF FATHER Alfred Nelson Walker11. BIRTHPLACE OF FATHER Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Agnes McDonald13. BIRTHPLACE OF MOTHER Springfield - Utah
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred Nelson Walker(Address) Montpelier, Ida.15. 9-14-23 W. H. King
Filed _____ 19 _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 14 23
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____,
that I last saw h. _____ alive on Born dead 19____,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature birth
(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ Yrs. _____ mos. _____ ds.
(Signed) W. H. King M. D.
_____ 19____ (Address) Montpelier

*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Montpelier Ida DATE OF BURIAL 9-14-192320. UNDERTAKER Alfred Blauer ADDRESS Montpelier

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

JAN 8 1924

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS
District No. 23

Primary Registration District No. 1017-2017

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. S 44113

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME unnamed Pyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

Oct 7 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or
..... min.

..... yrs. mos. 0 da.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Jerome, Ida

10. NAME OF FATHER

Wm. Pyne

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lillie Worthington

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. P. Keller

(Address)

Jerome, Ida

15.

Filed Oct 7 1924 E.D. Piper M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 7 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 7 1923 to Oct 7 1923

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still Born Infant

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. P. Keller M.D.

107 1923 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chas. P. Keller

Oct 7 1924

20. UNDERTAKER

ADDRESS

Wm. Pyne (father)

Jerome

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Twin Falls*
City of *Idaho*Registration District No. *37*Primary Registration District No. *1085*(No. *Hospital*) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant - Wheelwright*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *S 44296*
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Dec 3 1923
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.IF LESS than 1 day
how many *0* hrs.
or *0* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Twin Falls*

10. NAME OF FATHER

Roy Wheelwright

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

Virginia Corbin

13. BIRTHPLACE OF MOTHER

(State or Country) *Kentucky*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Roy Wheelwright*(Address) *Twin Falls, Ida*

15.

Filed *Dec. 31-23**John F. Goughlin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 3 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:*Still born.*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

Dec 11 1923

20. UNDERTAKER

J. E. Dewitt

ADDRESS

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

652-106-031-745
DATE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Lewis
City of Nezperce, RFD
No. _____ St. _____ Registration District No. 47 File No. 107218
Hospital _____ Primary Registration District No. _____ Registered No. 205
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other _____ } and } Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>Jan, 6</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	--	----------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME <u>FATHER</u> <u>Carl C. Wester</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Lola Gregg</u>
RESIDENCE <u>Nezperce, RFD</u>	RESIDENCE <u>Nezperce, RFD.</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Co. Black Hawk, Iowa</u>	BIRTHPLACE <u>Calhoun Co., Iowa</u>
OCCUPATION <u>rancher</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 7 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. E. Duval, M.D.
(Physician or midwife)

Give names added from a supplemental report.
Albert Huff, 19
Registrar.

Address Craigmont, Idaho.
Filed 1 8 1923 Albert Huff
Registrar.



CONFIDENTIAL

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of LewisCity of Nezperce, RFD. 2

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47

Primary Registration District No. _____

(No. _____ St.)

2. FULL NAME

StillbornState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 91Registered No. 40609

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single (Use the word.)

6. DATE OF BIRTH

Jan. 6

(Month)

(Day)

1923 (Year)

7. AGE

0

Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nezperce, RFD

10. NAME OF FATHER

Carl C. Wester

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Eola Gregg

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 1-8 19 23

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan.623.

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Nov. 61923to Jan. 61923that I last saw him alive on 19and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. E. Dunlap M. D.1/6 23(Address) Graigmont, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Myrene Cemetery1 7 1923

20. UNDERTAKER

ADDRESS

Albert HuffMyrene Hobbs

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

213-127-003-466
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

108429

CERTIFICATE OF BIRTH

S

85

County of Bannock RECEIVED

City of Pocatello FEB 8 1923

No. 431 S. 2nd Registration District No. 28

File No.

Hospital STATISTICS

Primary Registration District No. 2161

Registered No. 4777

FULL NAME OF CHILD

Baby Battles

(dead)

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>1-27-1923</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER	MOTHER
FULL NAME <u>Don E Battles</u>	FULL MAIDEN NAME <u>Clemmie Moore</u>
RESIDENCE <u>Pocatello</u>	RESIDENCE <u>same</u>
COLOR <u>Black</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>Black</u> AGE AT LAST BIRTHDAY <u>16</u> (Years)
BIRTHPLACE <u>Mo.</u>	BIRTHPLACE <u>ark.</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>hwp.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was dead at 1:05 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

[Signature]

(Physician or midwife)

Give names added from a supplemental report.

Address

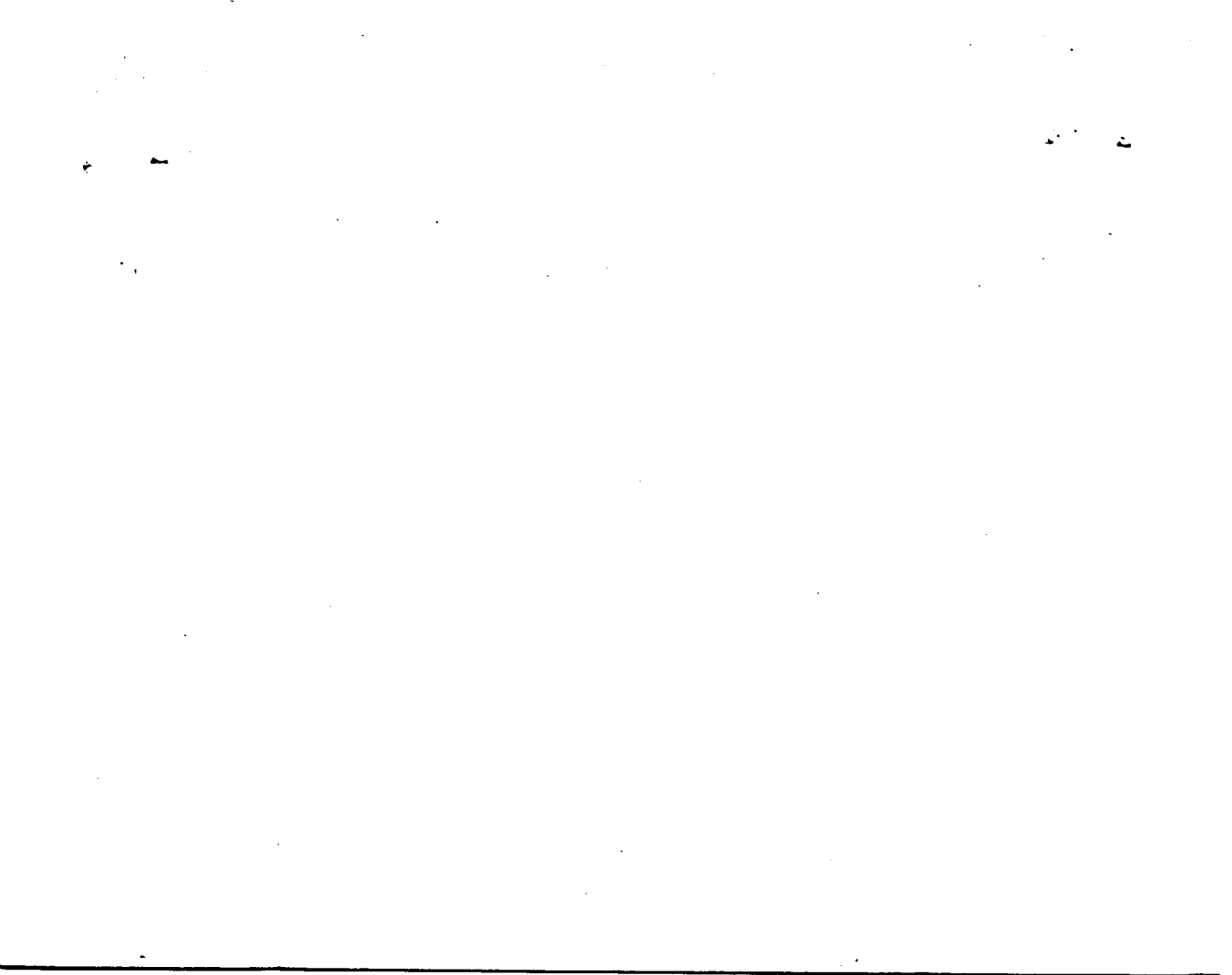
Pocatello Ida

Filed

21 1923

Registrar.

Registrar.



CERTIFICATE OF DEATH

40789

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 58

Registered No. 4016

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

1/28

1923

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

667-215-805-367
PLACE OF BIRTH
RECEIVED
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Bennett F. D. No. 1923
City of Bennett BUREAU OF VITAL STATISTICS
No. _____ St. Registration District No. 31 File No. 108445
Hospital _____ Primary Registration District No. _____ Registered No. 38
FULL NAME OF CHILD Sarah Elizabeth Fox
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Jan 15</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------	--

What bacterioidal solution was used in eyes? _____

Number of child of this mother, including present birth. _____ Number of children of this mother now living, including present birth. _____

FATHER FULL NAME <u>Frank Fox</u>		MOTHER FULL MAIDEN NAME <u>Sarah E. Fox</u>	
RESIDENCE <u>Bennett Idaho</u>		RESIDENCE <u>Bennett Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Michigan</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 1 P M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Fred. Bartman

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed 15 January 1923 Y. L. Brian
Registrar.

FORM NO. 1
 MAY 1962 EDITION
 GSA GEN. REG. NO. 27
 (4-74)
 PREVIOUS EDITIONS OBSOLETE

FULL NAME IN CHINESE

Date of Birth (Month/Day/Year)	Place of Birth (City/Town/Village)	Sex Male / Female	Nationality Chinese / Other
-----------------------------------	---------------------------------------	----------------------	--------------------------------

All information on this form was used to create a permanent record of the individual's identity.

MOTHER Name Address	FATHER Name Address
----------------------------------	----------------------------------

AGE AT LAST BIRTHDAY (Year/Month/Day)	AGE AT LAST BIRTHDAY (Year/Month/Day)
---	---

OCCUPATION: _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date specified below.

(Signature) _____

(Address) _____

(Date) _____

(Name) _____

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 2/12 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

RECEIVED
FEB 26 1923
BUREAU OF VITAL
STATISTICS

Place of Birth (CITY Westmet FILE NO. 108445
ST. _____ DATE OF BIRTH Jan. 15-1923
COUNTY Benevolence SEX OF CHILD Female
FATHER Frank, Hughes Fox MOTHER Sarah Elizabeth Fox
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Sarah, Elizabeth, Fox
Mrs. Sarah E. Fox

Signature of Father or Mother.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 2 40805Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 31
County of Bennett Primary Registration District No. _____
City of Desmet _____ St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
FEB 5 1923
BUREAU OF VITAL STATISTICS

2. FULL NAME

Unmarried Fox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

7. White (Write the word.)

6. DATE OF BIRTH

Jan 15 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

Yrs. _____ Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Fox

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Larrah E. Cox

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Fox(Address) Desmet, Ida.

15.

Filed Jan 16 1923Y. L. Bihan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 15 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) Frank Barber M. D.19 (Address) Desmet, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. _____ mos. _____ days. In the State yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Desmet, Ida.

DATE OF BURIAL

Jan 16 1923

20. UNDERTAKER

Frank Fox

ADDRESS

Desmet

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

492-111-006-812

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH-

STATE OF IDAHO
BUREAU OF VITAL STATISTICSCounty of Bannock

RECEIVED

FEB 8 1923

CERTIFICATE OF BIRTH

S 108448

City of Blackfoot

BUREAU OF VITAL

STATISTICS

No. 70 of town St.Registration District No. 121

File No. _____

Hospital _____

Primary Registration District No. 2194Registered No. 38FULL NAME OF CHILD Rogers, MireSex of Child MaleTwin
Triplet
or other?
(To be answered only in event of plural births)

{ and }

Number
in order
of birthLegiti
mateDate of
Birth

(Month)

(Day)

(Year)

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth 2Number of children of this mother now living, including present birth 1I hereby certify that I attended the birth of this child, who was born alive or stillborn at 8 P.M. on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

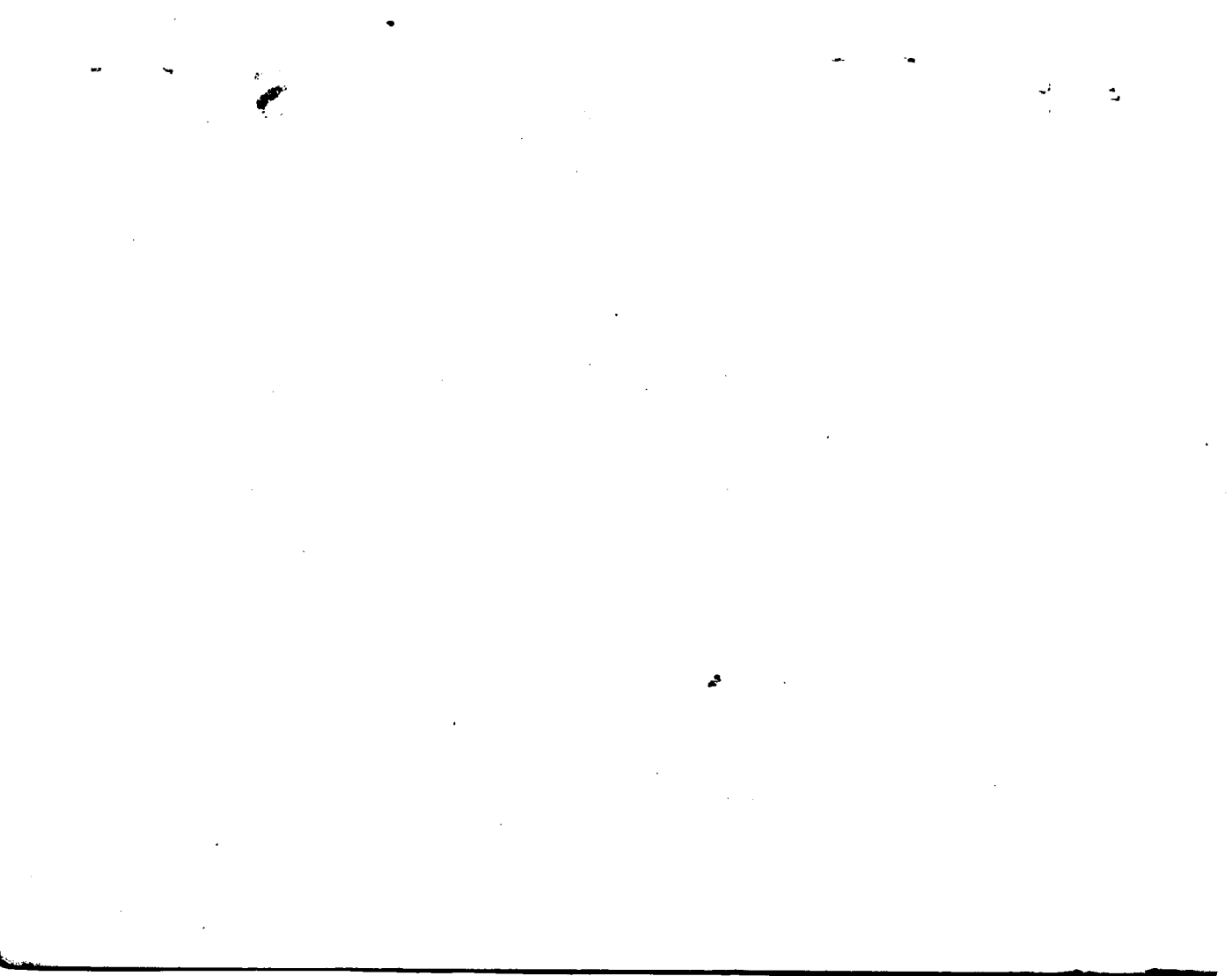
Address Blackfoot, IdaFiled Feb. 7 19 23

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40813
File No. 5
Registered No. 5

1. PLACE OF DEATH Bingham FEB 8 1923
County of Bingham Registration District No. 171
City of Bingham Primary Registration District No. 2194
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rogn Misa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Japanese 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Jan. 11th 1923
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION None
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Bingham Co Idaho
(State or Country)

10. NAME OF FATHER Dr. Misa

11. BIRTHPLACE OF FATHER Japan
(State or Country)

12. MAIDEN NAME OF MOTHER Mrs. Yot Hayama

13. BIRTHPLACE OF MOTHER Japan
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Detimatsu Misa
(Address) Blackfoot Ida. Route 3

15. Filed Jan 12 1923 Wm. M. Misa Local Registrar

16. DATE OF DEATH Jan 11th 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1923 to Jan 11 1923
that I last saw him alive on Jan 11 1923
and that death occurred on the date stated above, at 8¹⁰ M.

The CAUSE OF DEATH* was as follows:
Stillborn - Placental
preria trunk
presentation
(Duration) Yrs. mos. ds.

Contributory (Secondary) None
(Duration) Yrs. mos. ds.
(Signed) W. E. Patric M. D.
(Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Blackfoot Ida DATE OF BURIAL Jan 12 1923

20. UNDERTAKER Detimatsu Misa ADDRESS Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e.g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 5 years)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as, "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences, (e.g., *sepsis, tetanus*) may be stated under the head of "Contributory."

317-114-04-381

PLACE OF BIRTH

County of *Canyon*City of *Nampa*No. *R.R.*

Hospital

FULL NAME OF CHILD

BUREAU OF VITAL STATISTICS

Primary Registration District No. *2006*

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Form V. S. No. 11-O-25m-4-4-17

S108546

File No.

Registered No.

Sex of Child <i>Male</i>	Twin Triplet or other? <i>x</i> and Number in order of birth <i>1</i>	Legitimate? <i>yes</i>	Date of Birth <i>Jan 14 1923</i> (Month) (Day) (Year)
--------------------------	---	------------------------	--

FULL NAME <i>J. D. Taggart</i>	FATHER
RESIDENCE <i>Nampa Idaho</i>	
COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>60</i> (Years)
BIRTHPLACE <i>Maryland</i>	
OCCUPATION <i>Farmer</i>	

FULL MAIDEN NAME <i>Laura Chadbourne</i>	MOTHER
RESIDENCE <i>Nampa Idaho</i>	
COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>46</i> (Years)
BIRTHPLACE <i>Minn.</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth. *7*..... Number of children of this mother now living, including present birth. *5*.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Born dead* at *4:30 P.* on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *J. H. Murray*
M. D.
(Physician or midwife)

Given names added from a supplemental report.

Address *Nampa Idaho*
Filed *Feb. 6 1923* *Pearle Dodds*
Registrar



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40831

1. PLACE OF DEATH

County of *Canyon*City of *Tampa*Registration District No. *7*Registration District No. *2506*

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of J. D. Taggart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.) *Single*

6. DATE OF BIRTH

Jan

(Month)

14

(Day)

1923

(Year)

7. AGE

Dead born

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Canyon Co. Idaho*

10. NAME OF FATHER

J. D. Taggart

11. BIRTHPLACE OF FATHER

(State or Country) *Maryland*

12. MAIDEN NAME OF MOTHER

*Laura Chadborn
Nancy Brown*

13. BIRTHPLACE OF MOTHER

(State or Country) *Minnesota*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. D. Taggart

(Address)

Tampa, Minn

15.

Filed

Feb 6

1923

Pearle Dodd

Local Registrar

MEDICAL CERTIFICATE OF DEATH

189-6

16. DATE OF DEATH

Jan

(Month)

14

(Day)

1923

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1923, to *Jan 14* 1923that I last saw him *1300* alive on *Jan 14* 1923and that death occurred on the date stated above, at *4:20* P.M.

The CAUSE OF DEATH* was as follows:

*Dead at birth -
two weeks before expected time of birth*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. I. Murray

M. D.

1/15/1923 (Address) *Tampa Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Tampa Idaho

DATE OF BURIAL

1-17 1923

20. UNDERTAKER

Frank E. Robinson

ADDRESS

Tampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

912-105-021-555
PLACE OF BIRTH

RECEIVED
FEB 9 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin

City of Merton

BUREAU OF CERTIFICATE OF BIRTH
STATISTICS

108596

No. _____ St. _____

Registration District No. 27

File No. _____

Hospital _____

Primary Registration District No. 2119

Registered No. 4

FULL NAME OF CHILD 5 mce Mertanian

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ } and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth. <u>Jan 5</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 9 Number of child of this mother now living, including present birth... 8

FATHER
FULL NAME J P Rammeren
RESIDENCE Merton Idaho
COLOR white AGE AT LAST BIRTHDAY 47 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Sarah Jensen
RESIDENCE Merton Idaho
COLOR white AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Idaho
OCCUPATION House keeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 3:30 P M.
on the date above stated. (Born alive or stillborn)

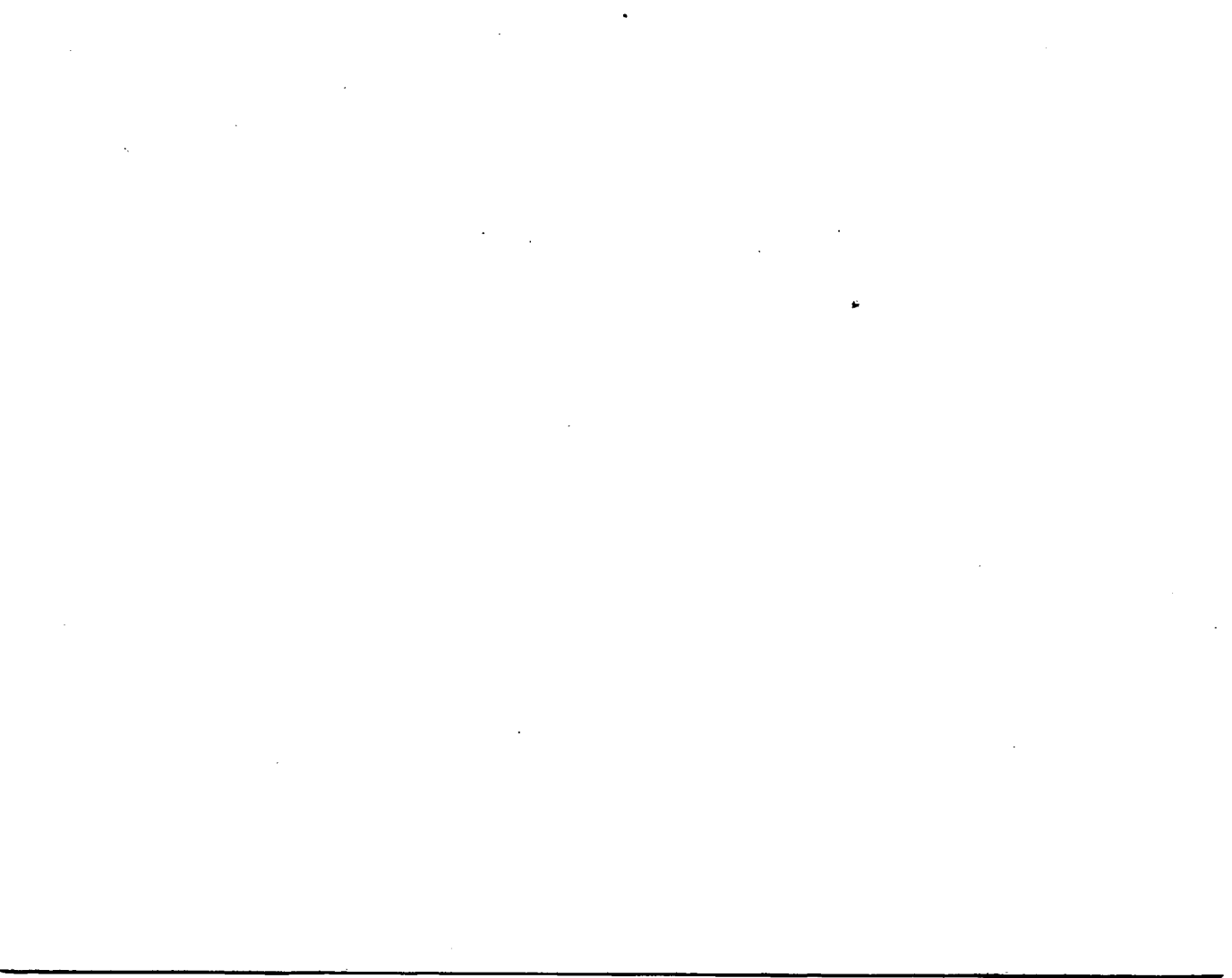
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Thos B Holder
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19_____

Registrar.

Address Merton Idaho
Filed Jan 4 1923 Mrs Ida Lippert
Registrar.



WRITE PLAINLY WITH UNFADING INK - THIS IS A PERMANENT RECORD
N.B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

962.203-025-619

PLACE OF BIRTH

Form V. S. No. 11-C-25m-9-8-37

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

County of Idaho

FEB 6 1923

CERTIFICATE OF BIRTH

City of Cottonwood

BUREAU OF VITAL

Registration District No.

105

File No.

S108635

No. St.

Primary Registration District No. 2183

Registered No.

Hospital

FULL NAME OF CHILD

Laura Pearl Robbins

Sex of Child

Female

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of Birth

1.....3.....1923
(Month) (Day) (Year)

FULL NAME

FATHER

Walter Robbins

FULL MAIDEN NAME

MOTHER

Violine Farmer

RESIDENCE

Cottonwood

RESIDENCE

Cottonwood

COLOR

White

AGE AT LAST BIRTHDAY

28
(Years)

COLOR

White

AGE AT LAST BIRTHDAY

38
(Years)

BIRTHPLACE

Cottonwood Idaho

BIRTHPLACE

West Virginia

OCCUPATION

Farmer

OCCUPATION

Housewife

Number of child of this mother, including present birth 7..... Number of children of this mother now living, including present birth 5.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 10 P.M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. D. Shinnick M.D.

(Physician or midwife)

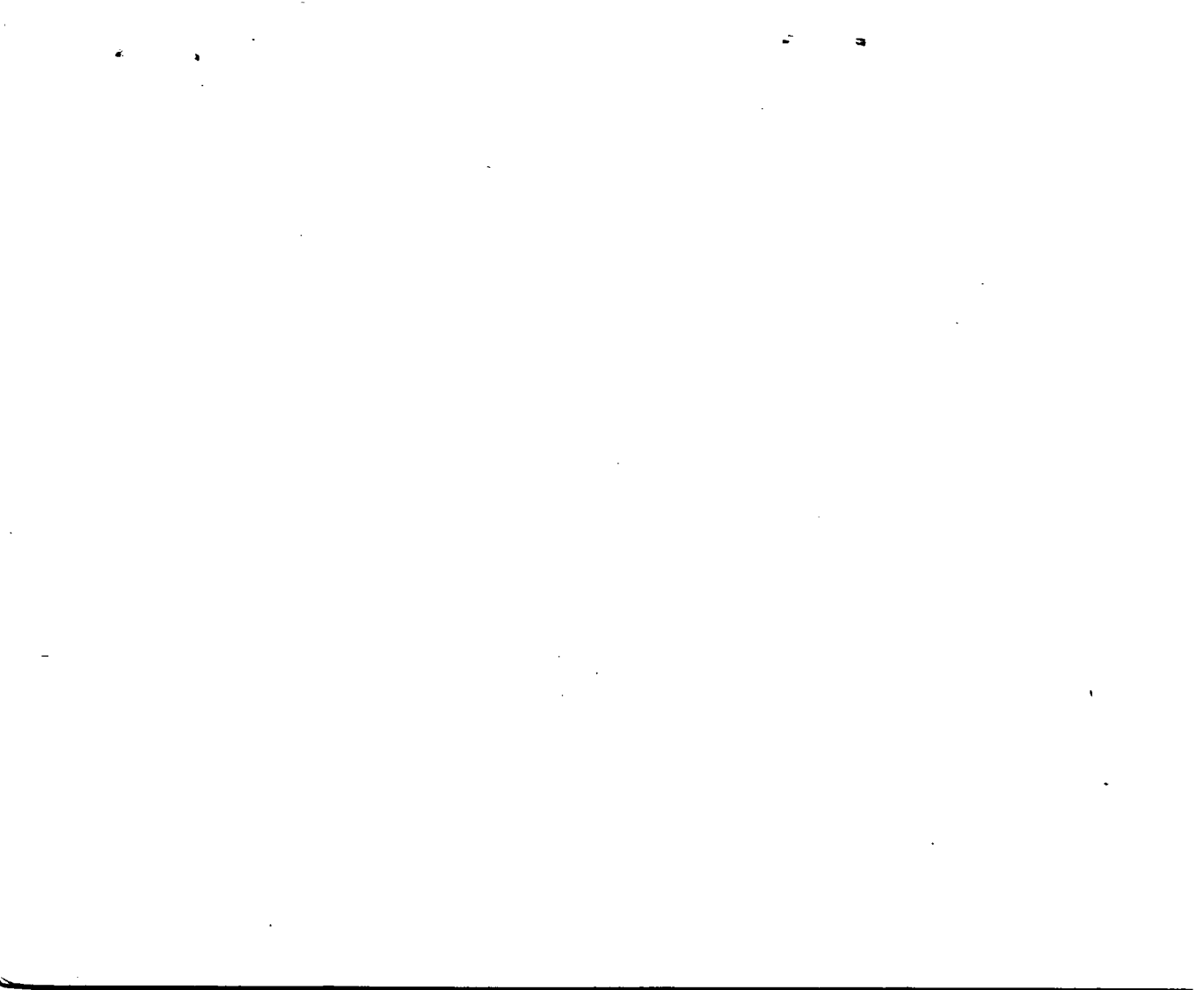
Given names added from a supplemental report.

Address Cottonwood Idaho

Filed Feb 1 1923 W. F. Orr

Registrar

Registrar



FORM V. S. No. 5-25 M. 1-19

CERTIFICATE OF DEATH

40879

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of CottonwoodRegistration District No. 105Primary Registration District No. 2183(No. 1146 St.)File No. 1

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lama Pearl Roffins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

January 3 1923
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Walter Roffins

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Vinnie Farmer

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. A. Rustmeyer
(Address) Cottonwood, Idaho

15.

Filed Feb 2 1923 W. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 3 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1923 to Jan 3 1923
that I last saw him alive on Still born 19
and that death occurred on the date stated above, at 11 M.
The CAUSE OF DEATH* was as follows:
Still Born

(Duration) Yrs. mos. ds.

Contributory Transverse myelitis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Shumacher M. D.1-3 1923 (Address) Cottonwood, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cottonwood 1-4 1923

20. UNDERTAKER

Chas. Cottonwood Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

242-1271025-258
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho
City of Grangeville
No. 103 St. 103 File No. 108643
Hospital not named Primary Registration District No. 2181 Registered No. 3
FULL NAME OF CHILD not named
(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twin Triplet or other? <u>no</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Jan 27</u> 192 <u>3</u> (Month) (Day) (Year)
-----------------------	----------------------------------	-----	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER FULL NAME <u>Harvey Kube</u> RESIDENCE <u>Grangeville Ida</u> COLOR <u>w</u> AGE AT LAST BIRTHDAY <u>29</u> (Years) BIRTHPLACE <u>S. Dakota</u> OCCUPATION <u>Farmer</u>	MOTHER FULL MAIDEN NAME <u>Addie Behean</u> RESIDENCE <u>Grangeville Ida</u> COLOR <u>w</u> AGE AT LAST BIRTHDAY <u>25</u> (Years) BIRTHPLACE <u>Idaho</u> OCCUPATION <u>Housewife</u>
--	---

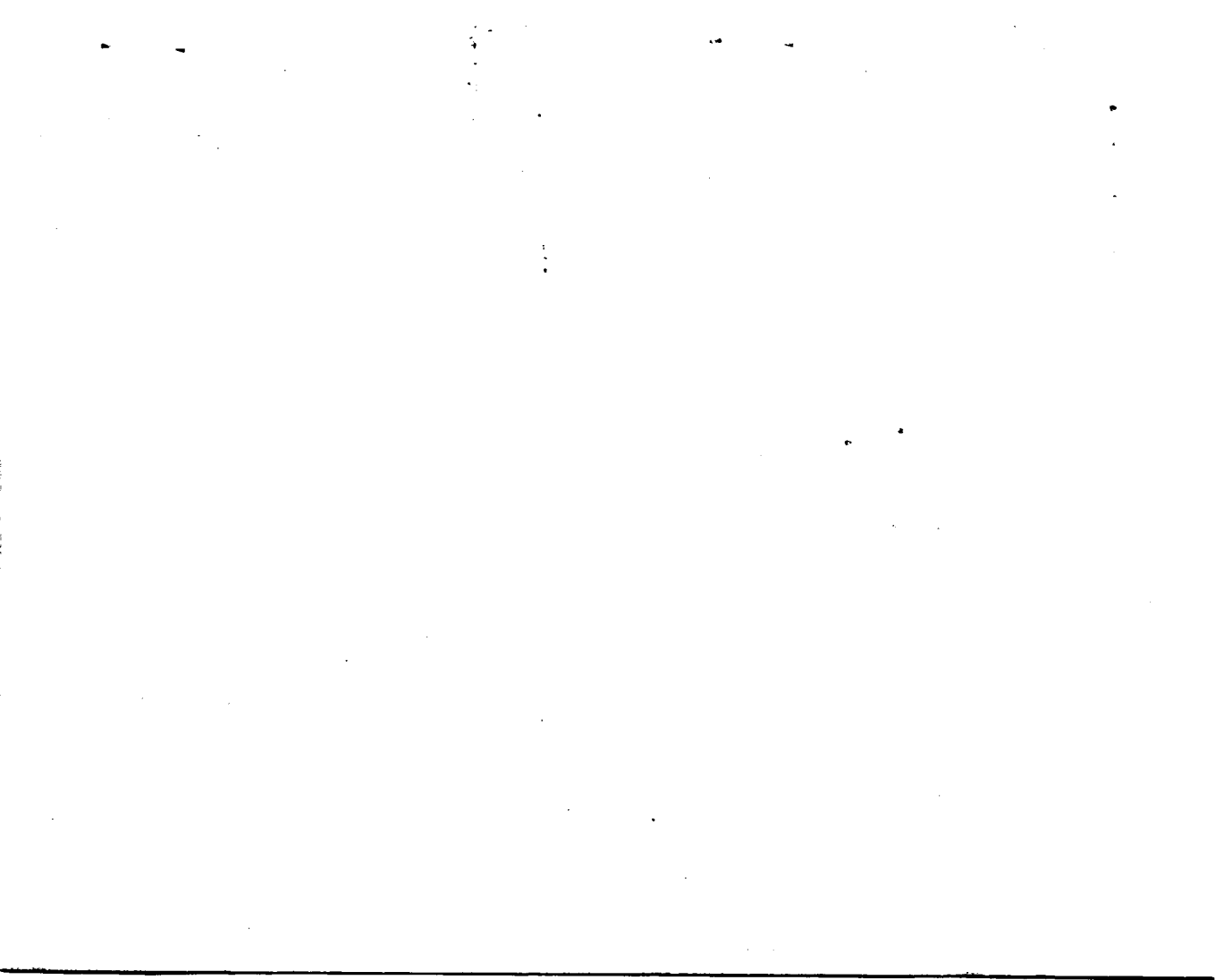
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born, at 2¹⁴ P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 19.....
Registrar.

(Signature) G. S. Stockton
(Physician or midwife)
Address Grangeville Ida
Filed Feb 1 1923 G. S. Stockton
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Idaho
City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
FEB 8 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 103
Primary Registration District No. 2181 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40877
Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan 27 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Harry Kube

11. BIRTHPLACE OF FATHER

(State or Country) S. Dakota

12. MAIDEN NAME OF MOTHER

Addie Behean

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. S. Stockton

(Address)

Grangeville Idaho

15.

Filed

Feb 1 1923 G. S. Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 27 1923 to Jan 27 1923

that I last saw him alive on Jan 27 1923

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Premature Birth
7 months gestation

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. S. Stockton M. D.

1/27/1923 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Denver Idaho

DATE OF BURIAL

Jan 28 1923

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

1590

381-210-033-719
PLACE OF BIRTH

RECEIVED
FEB 5 1923
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison
City of Rexburg
No. _____ St. _____
Hospital _____

Registration District No. 100 File No. 108704
Primary Registration District No. 2178 Registered No. 324

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and {	Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>1-10-</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	----------------------------------	-------	------------------------------------	------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth... 2 ... Number of child of this mother now living, including present birth... 2 ...

FULL NAME Leo Vernon Chappie FATHER
RESIDENCE Rexburg
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Utah
OCCUPATION Printer

FULL MAIDEN NAME Rebecca MOTHER
RESIDENCE Rexburg
COLOR White AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born at 8 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Lorin A. Rich

(Physician or midwife)

Give names added from a supplemental report.

Address

Rexburg Idaho

Filed

1-10 1923

Registrar.

Registrar.

THOMAS HARRISON, Plaintiff
vs.
JAMES HARRISON, Defendant

FULL NAME OF PLAINTIFF

Plaintiff
Name
Address
City

OF ATTORNEY

CERTIFICATE OF ATTORNEY

I am a duly qualified attorney at law in the State of Iowa, and I hereby certify that the foregoing is a true and correct copy of the original of the within and foregoing instrument, as the same appears from the records of my office.

RECEIVED
1923
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho JAN 16 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Rexburg) FILE NO. 108704
(ST. _____) DATE OF BIRTH January 10, 1923
(COUNTY Madison) SEX OF CHILD Female
FATHER Leo Vernon Chapple
MOTHER Rebecca Porter
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Baby Chapple (Born dead)

Leo V. Chapple

Signature of Father or Mother.

APR 26 1965

Simple direct line on this line

1100

1100

1100

1100

1100

1100

1100

1100

1100

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison District No. 700
City of Redburg Primary Registration District No. 2178
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

JAN 5 1923

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED infant
(Write the word.)

6. DATE OF BIRTH

January 10 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
Yrs. Mos. da. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).infant

9. BIRTHPLACE

(State or Country)

Redburg, Idaho

10. NAME OF FATHER

Leo Vernon Chapple

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Rebecca Porter

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leo Vernon Chapple
Redburg - Idaho

(Address)

15.

Filed

1/10 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 10 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
1-10-1923 to 1-10-1923
that I last saw her alive on 1-10-1923
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature birth
Stillborn(Duration) Yrs. mos. ds.
Contributory (Secondary) Conjugal hydrocephalus(Duration) Yrs. mos. ds.
(Signed) Leo V. Chapple M. D.1/11 1923 (Address) Redburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Redburg

DATE OF BURIAL

1-12-1923

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

693-110-507-214

PLACE OF BIRTH

County of AdaCity of BoiseNo. 373 Bannock St.

Hospital

FULL NAME OF CHILD

BUREAU OF VITAL

STATISTICS

Primary Registration District No.

Still Born

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Form V. J. No. 12-C-25m-3-3-3

S

File No. 108839Registered No. 37

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>Feb 10 1923</u> (Month) (Day) (Year)
FULL NAME <u>Edward Frank Wilcox</u>	FATHER	FULL MAIDEN NAME <u>Francis S. Samuels</u>	MOTHER	
RESIDENCE <u>373 Bannock</u>		RESIDENCE <u>373 Bannock</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)	
BIRTHPLACE <u>Ogden, Ut.</u>		BIRTHPLACE <u>Oakley, Ida.</u>		
OCCUPATION <u>Salesman</u>		OCCUPATION <u>House wife</u>		

Number of child of this mother, including present birth..... Number of children of this mother now living, including present birth.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was..... at 8-30 P M. on the date above stated.

(If born alive stillborn)

*When there was no attending Physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature)

Geo. W. Hender, D.O.
(Physician or midwife)

Address.....

Filed.....

Registrar

Registrar

THE UNIVERSITY OF CHICAGO

4

Nandy

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
 City of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
 MAR 3 1923
 BUREAU (No. 323 N. Bannock St.)
 STAT.

2. FULL NAME

Registration District No. 2
 Primary Registration District No. 1004
323 N. Bannock St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40977
 Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

M. White Single
 (write age word.)

6. DATE OF BIRTH

Feb-10-1923
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

If LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country) Boise Idaho

10. NAME OF FATHER

Edwin S. Wilcox

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Frances Samundson

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) 708 Rubblow

15.

Filed Feb 13 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb-10 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 10 1923, to Feb 10 1923
 that I last saw him alive on Dead Feb 10 1923
 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.
 Contributory (Secondary) pregnation
8 months

(Duration) yrs. mos. ds.
 (Signed) E. H. Bundy

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Morris Mission Feb 11 1923

19. UNDERTAKER

ADDRESS

Summers Bros Boise Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

455-229.005-255
PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-25m-9-8-15

County of Bennett **RECEIVED**
City of St. Maries **FEB 17 1923**
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

32

S 108869

File No.

No. _____ St.

Primary Registration District No. 2049

Registered No. 21

Hospital _____

FULL NAME OF CHILD

Still born - Baby Glenison

Sex of Child female Twin Triplet or other? _____ and _____ Number in order of birth 1st Legitimate? yes Date of Birth Jan 29 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER
FULL NAME Ray J. Glenison
RESIDENCE St. Maries Ida
COLOR white AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Washington
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Thesa M. Benedict
RESIDENCE St. Maries Ida
COLOR white AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Idaho
OCCUPATION housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born dead at 1:40 a on the date above stated. (Became alive or stillborn) M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]
(Physician or midwife)

Given names added from a supplemental report.

Address St. Maries, Idaho
Filed Jan 29 1923 [Signature]
Registrar

Seneca half month old

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
that I last saw him alive on
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

693-125-209-115

PLACE OF BIRTH

RECEIVED

MAR 6 1923

STATE OF IDAHO

Form V. S. No. 11—20m-7-26-19

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of

Bonne

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S108879

City of

Rush Run

Registration District No.

25

File No.

4

No.

St.

Hospital

Rush Run

Primary Registration District No.

285

Registered No.

243

FULL NAME OF CHILD

Leon William

Sex of Child

M

Twin
Triplet
or other?

and

Number
in order
of birthLegiti-
mate?

yes

Date of
Birth

Feb 25 1923

(Month) (Day) (Year)

FULL
NAME

FATHER

Carl William

RESIDENCE

Foshin Lac

COLOR

W.

AGE AT LAST
BIRTHDAY23
(Years)

BIRTHPLACE

Mich.

OCCUPATION

Mechanic

FULL
MAIDEN
NAME

MOTHER

Grace Gonaski

RESIDENCE

Foshin Lac

COLOR

W.

AGE AT LAST
BIRTHDAY29
(Years)

BIRTHPLACE

Mich.

OCCUPATION

Housewife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. J. Gatzert
at 12:15 P.M.
(Born alive or stillborn)
J. J. Gatzert
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Rush Run

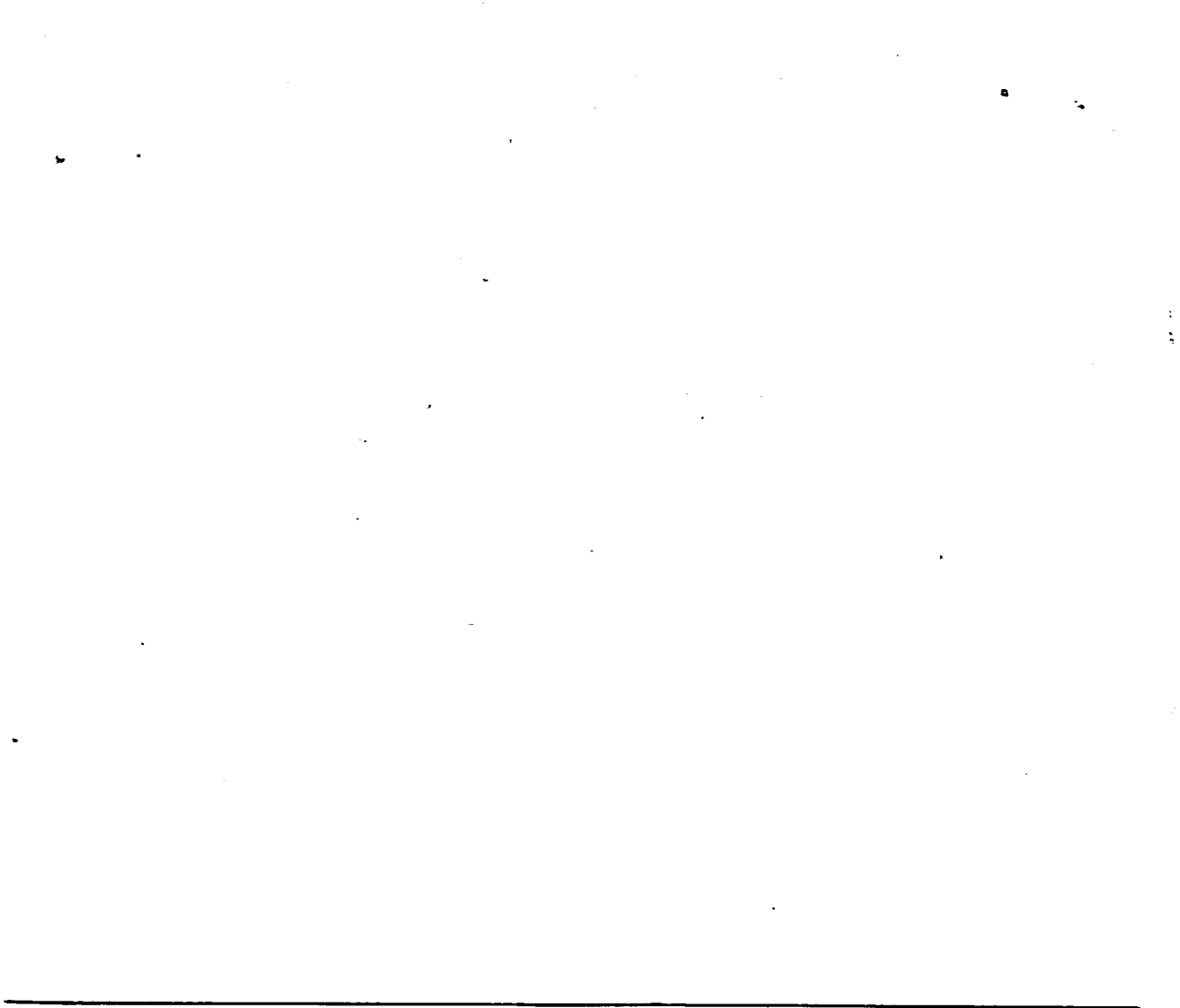
Filed

March 1923

1923

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

✓ 41004
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Boone*City of *Boone*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leon William

RECEIVED
JAN 26 1923
BUREAU OF VITAL STATISTICS

Registration District No. *25*Registration District No. *25*File No. *3*Registered No. *85*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Feb 25 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *March 1**19**23*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 25 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Shell bomb

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

745-212-009-248
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

MAR 6 1923

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

108890

County of Bonner

City of Ponderay

No. _____ St. _____

Registration District No. 7E

File No. 108890

Hospital _____

Primary Registration District No. 2155

Registered No. _____

FULL NAME OF CHILD still born

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? _____ { and } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>2/12/23</u> 192____ (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FULL NAME FATHER
Ralph Andrew Gunderson

FULL MAIDEN NAME MOTHER
Monie Boyd

RESIDENCE Ponderay

RESIDENCE Ponderay

COLOR W AGE AT LAST BIRTHDAY 35 (Years)

COLOR W AGE AT LAST BIRTHDAY 31 (Years)

BIRTHPLACE Wis.

BIRTHPLACE Minn.

OCCUPATION _____

OCCUPATION Haw

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born, at 9 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]

M.D.

(Physician or midwife)

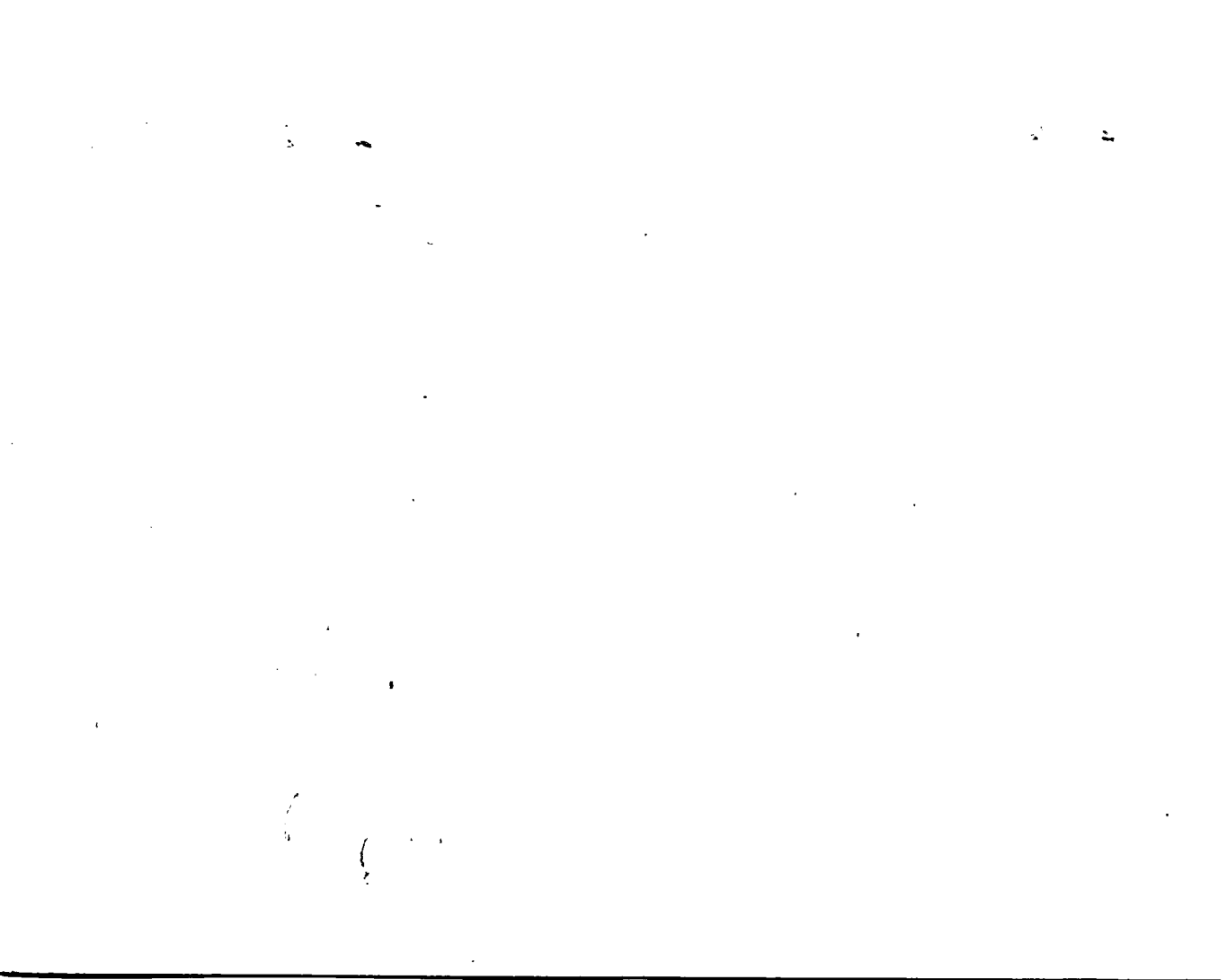
Give names added from a supplemental report.

Address Sandpoint, Ida

Filed March 7, 1923

Viola Allen
Deputy Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonner
City of Ponderay

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAR 6 1923

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78
Registration District No. 2153
City of Ponderay (Nov.) St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41012
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby "Sunderson"

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Feb 12 1923
(Month) (Day) (Year)

7. AGE

StilbornIF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

Ralph Sunderson

11. BIRTHPLACE OF FATHER

(State or Country) Wis.

12. MAIDEN NAME OF MOTHER

Mamie Boyd.

13. BIRTHPLACE OF MOTHER

(State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Sunderson
(Address) Ponderay Idaho.15. Filed March 3 1923Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

FEB 12 1923

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
that I last saw him _____ alive on _____ 19____,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows;

Asphyxiation during birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. D. Allen M. D.2-25-23 (Address) Sungate, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lakeview Cemetery

DATE OF BURIAL

2/22 1923

20. UNDERTAKER

Dr. Moon

ADDRESS

Sungate, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

519-118-014-365
PLACE OF BIRTH

RECEIVED
FEB 17 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

108947

County of Canyon

City of Caldwell

No. 1507 Arthur

St.

Registration District No.

File No.

Hospital

Primary Registration District No. 1005

Registered No.

6

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of
Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

1/10

1923

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Harry O. Vail

RESIDENCE

1507 Arthur St. Caldwell, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

32

(Years)

BIRTHPLACE

Kansas

OCCUPATION

Truckman

FULL
MAIDEN
NAME

MOTHER

Pearl Cover

RESIDENCE

1507 Arthur St. Caldwell, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

33

(Years)

BIRTHPLACE

Neb.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 1:30 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

S. B. Dudley

M. D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Caldwell, Idaho

Filed

Jan. 13- 1923

John H. Meyer
Registrar.

Registrar.

CERTIFICATE

OF THE
UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho 3/13 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth (CITY Caldwell FILE NO. 108947
 (ST. 1507 Arthur DATE OF BIRTH Jan. 10 1923
 (COUNTY Canyon SEX OF CHILD Male
 FATHER Harry A. Hall MOTHER Pearl Crow
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

This baby died at birth (premature)

Mrs. Pearl Crow

Signature of Father or Mother

RECEIVED
 MAR 24 1923
 BUREAU OF VITAL STATISTICS

10-11-51

10-11-51

10-11-51

10-11-51

10-11-51

10-11-51

10-11-51

10-11-51

10-11-51

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

791-228-023-314
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

MAR 5 1923

County of Idaho City of Emmett No. _____ St. _____
Hospital _____ Primary Registration District No. _____ Registered No. _____
Registration District No. 6 File No. _____

CERTIFICATE OF BIRTH **109021**

FULL NAME OF CHILD _____
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and {	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>2</u> <u>28</u> <u>1923</u> (Month) (Day) (Year)
----------------------------	---	-------	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 14 Number of children of this mother now living, including present birth 3

FATHER
FULL NAME Eugene J. Gratton
RESIDENCE Emmett
COLOR white AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Mich
OCCUPATION Sawyer

MOTHER
FULL MAIDEN NAME Anna Campbell
RESIDENCE Emmett
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born 230 a M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

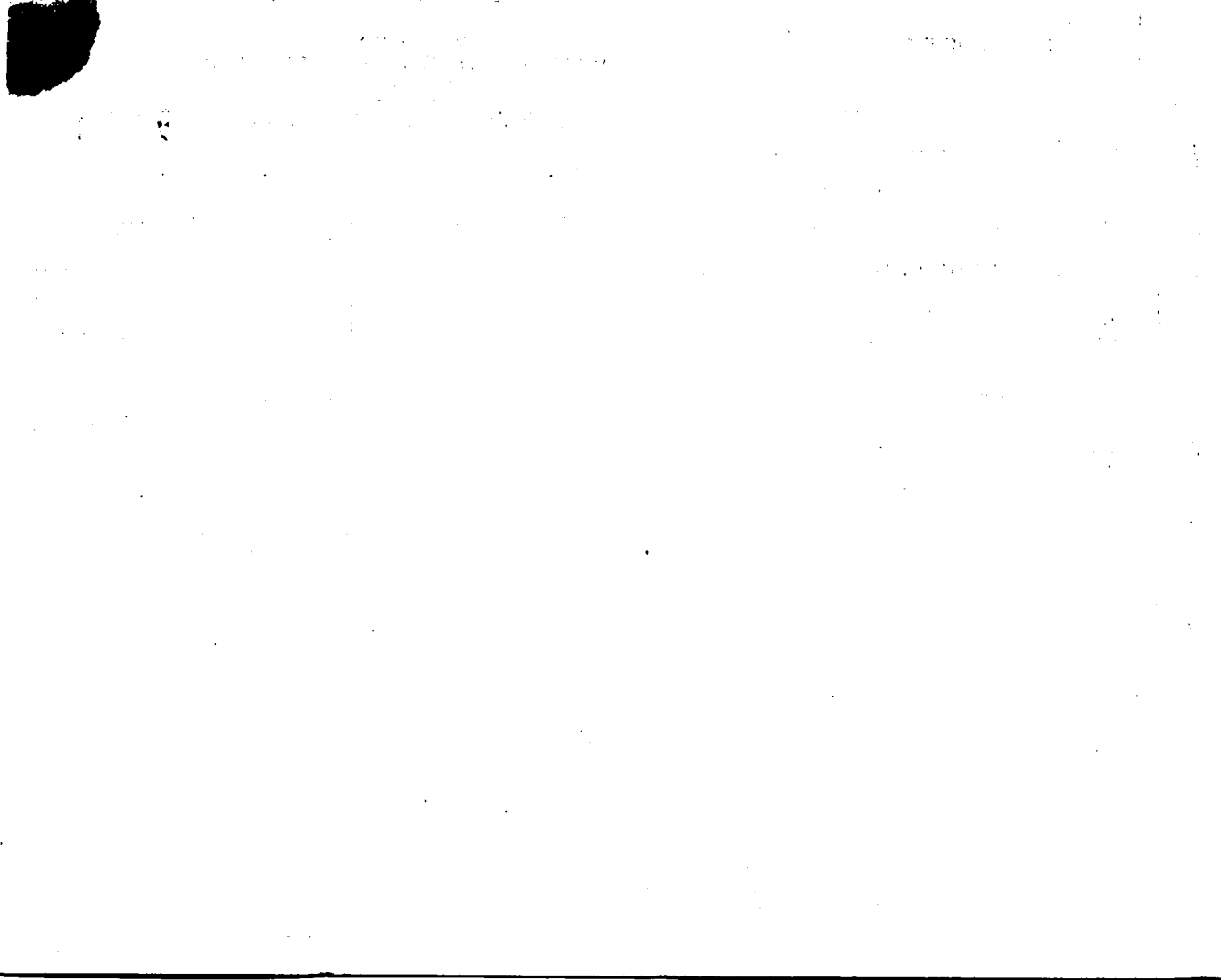
(Signature) R. H. Cummings

(Physician or midwife)

Give names added from a supplemental report.
_____, 192_____

Registrar.

Address Emmett
Filed 3/1 1923 J. H. Reynolds Registrar.



466-209-029-433
PLACE OF BIRTHSTATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-15

County of LatahRECEIVED
FEB 17 1923

CERTIFICATE OF BIRTH

City of _____

BUREAU OF VITAL
STATISTICS

65

File No.

S

109040

No. _____

St. _____

Primary Registration District No. 2145

Registered No. _____

Hospital _____

FULL NAME OF CHILD

(Unborn Infant) MooneySex of
Child

7

Twin
Triplet
or other?and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
Birth

Jan 9 1923

(Month) (Day) (Year)

FULL
NAMEFATHER
Robley E. MooneyFULL
MAIDEN
NAMEMOTHER
Larita McLean

RESIDENCE

5 Mi. E. Paton

RESIDENCE

Same

COLOR

WhiteAGE AT LAST
BIRTHDAY23
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY18
(Years)

BIRTHPLACE

Mont.

BIRTHPLACE

Utah

OCCUPATION

Farmer

OCCUPATION

Housewife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

(Signative or stillborn)

at 10 P. M.* When there was no attending physician or
midwife, then the father, householder, etc., should
make this return. A stillborn child is one that
neither breathes nor shows other evidence of life
after birth.

(Signature)

E. H. Wolf M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address

Paton

Filed

Jan 11th 1923Dr. J. W. Thompson

Registrar

REPORT OF BIRTH

THIS REPORT IS TO BE FILED IN THE BIRTH RECORDS OF THE STATE OF NEW YORK.

Form No. 1 (1914) (Revised 1915) (Approved by the State Board of Health, July 1, 1915)

PLACE OF BIRTH STATE OF NEW YORK COUNTY OF ... CITY OF ...		DATE OF BIRTH MONTH ... DAY ... YEAR ...	
FULL NAME OF CHILD ...		SEX OF CHILD ...	
FULL NAME OF FATHER ...		FULL NAME OF MOTHER ...	
RESIDENCE ...		RESIDENCE ...	
COLOR ...		COLOR ...	
BIRTHPLACE ...		BIRTHPLACE ...	
OCCUPATION ...		OCCUPATION ...	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was ... (Signature) ... (Physician or midwife) ...			
NUMBER OF CHILD IN THIS FAMILY ... NUMBER OF CHILDREN OF THIS MOTHER ...			

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED

CERTIFICATE OF DEATH

FEB 17 1923

Registration District No. 65

BUREAU OF VITAL STATISTICS

Registration District No. 3145

(No. , St.)

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41055

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Latah
City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Mooney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Infant
(Write the word.)

6. DATE OF BIRTH Jan 9 1923
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Stillborn
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Robley Mooney

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Laveta M. Lam

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ward M. Lam
(Address) Palouse, W.

15. Filed Jan 8 1923 D. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 9 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Jan 9 1923, to _____ 191—

that I last saw her alive on _____ 191—

and that death occurred on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. K. Hoyle M. D.

Jan 11 1923 (Address) Palouse, W.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Palouse, Wash. Jan 11 1923

20. UNDERTAKER ADDRESS

E. M. Irwin Palouse

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

355-204-835-355
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Key Pierce
City of Lewiston Ida

FEB 17 1923

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

109061

No. St. Registration District No. 96 State File No. 2

Hospital Primary Registration District No. 1009 Local Registrar's No. 2

FULL NAME OF CHILD Sing Lee Jr

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twins Triplet or other? <u>✓</u>	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth (Month) <u>Jan</u> (Day) <u>4</u> (Year) <u>1923</u>
(To be answered only in event of plural births)				

What bacteriocidal solution was used in eyes? —

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER	MOTHER
FULL NAME <u>Sing Lee</u>	FULL MAIDEN NAME <u>Yee Lee</u>
RESIDENCE <u>Lewiston Ida</u>	RESIDENCE <u>Lewiston Ida</u>
COLOR <u>Yellow</u> AGE AT LAST BIRTHDAY <u>42</u> (Years)	COLOR <u>Yellow</u> AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>China</u>	BIRTHPLACE <u>China</u>
OCCUPATION <u>Cook</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn 730 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Edgar E. Whitcomb, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Lewiston Ida

Filed 2/1 192 3

Registrar.

Registrar.

RECEIVED

CERTIFICATE OF DEATH

White
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41082**
Registered No. **3**

1. PLACE OF DEATH

County of Pres. Reg. Registration District No. 96
City of Leviston Primary Registration District No. 1009
(No. STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Ling Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

Yellow

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 4 1923
(Month) (Day) (Year)

7. AGE

SP

Mos. ds.

If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Stillborn

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ling Lee

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

Yee Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. Lee
Leviston, Ida.

15.

Filed

4/1/23

19

W. H. Hall

Local Registrar

16. DATE OF DEATH

Jan 4 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 4 1923 to Jan 4 1923

that I last saw he alive on Jan 4 1923

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Edgar L. White M. D.

(Address) Leviston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leviston Ida

4/5 1923

20. UNDERTAKER

ADDRESS

Vassar and Co.

Leviston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

319-213-036-522

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

7-21-19

County of Owyhee

FEB 17 1923

CERTIFICATE OF BIRTH

City of Malad

BUREAU OF VITAL
STATISTICS

Registration District No. 26

File No. 109067 A+B

No. _____ St. _____

Primary Registration District No. 2064

Registered No. 512

Hospital _____

FULL NAME OF CHILD

Stillborn

Sex of Child <u>Female</u>	Twin <u>Single</u> or other? <u>(To be answered only in event of plural births)</u>	and {	Number in order of birth <u>475</u>	Legiti mate? <u>Yes</u>	Date of Birth <u>1</u> <u>13</u> <u>1923</u> (Month) (Day) (Year)
----------------------------	--	-------	-------------------------------------	-------------------------	--

FATHER
FULL NAME Thurval Carlson
RESIDENCE Malad
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Norway
OCCUPATION Blacksmith

MOTHER
FULL MAIDEN NAME Anna Esklund
RESIDENCE Malad
COLOR White AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Scipio Utah
OCCUPATION Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 6 mos. 3 or 2 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. M. Kerns.
M. W.
(Physician or midwife)

Given names added from a supplemental report.

19

Address Malad Id.

Filed Feb 23 19 23

Registrar

Registrar



1
2
3
4

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

319-213-036-522

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

7-21-19

County of Owyhee

FEB 17 1923

CERTIFICATE OF BIRTH

City of Malad

BUREAU OF VITAL
STATISTICS

Registration District No. 26

File No. 109067 A+B

No. _____ St. _____

Primary Registration District No. 2064

Registered No. 512

Hospital _____

FULL NAME OF CHILD

Stillborn

Sex of Child <u>Female</u>	Twin <u>Single</u> or other? <u>(To be answered only in event of plural births)</u>	and {	Number in order of birth <u>475</u>	Legiti mate? <u>yes</u>	Date of Birth <u>1</u> <u>13</u> <u>1923</u> (Month) (Day) (Year)
----------------------------	--	-------	-------------------------------------	-------------------------	--

FATHER
FULL NAME Thurval Carlson
RESIDENCE Malad
COLOR white AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Norway
OCCUPATION Blacksmith

MOTHER
FULL MAIDEN NAME Anna Esklund
RESIDENCE Malad
COLOR white AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Scipio Utah
OCCUPATION Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 6 mos. 3 or 2 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. M. Kerns.
M. W.
(Physician or midwife)

Given names added from a supplemental report.

19

Address Malad Id

Filed Feb 23 19 23

Registrar

Registrar



1
2
3
4

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

413-103-038-219

PLACE OF BIRTH

County of Payette

City of Payette

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD

RECEIVED
FEB 17 1923
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S109084

Registration District No. 4 File No. _____

Primary Registration District No. 1008 Registered No. 3

Stillborn

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>Yes</u>	Date of Birth <u>Jan. 3 1923</u> (Month) (Day) (Year)
--------------------------	---	-----	---	----------------------------	---

FULL NAME <u>O.Z. Matthews</u>	FATHER
RESIDENCE <u>Payette, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Missouri</u>	
OCCUPATION <u>Farmer.</u>	

FULL MAIDEN NAME <u>Etta M. Barker</u>	MOTHER
RESIDENCE <u>Payette, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Oregon</u>	
OCCUPATION <u>Housewife.</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 2.00 A M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. C. Woodward
Physician
(Physician or midwife)

Given names added from a supplemental report.

19

Address Payette, Idaho

Filed Jan 3, 1923

J. C. Woodward
Registrar

Registrar

480951

STATIONER

OFFICE

RECEIVED
FEB 10 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 3/13 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

RECEIVED
MAR 19 1923
BUREAU OF VITAL
STATISTICS

Place of Birth (CITY Payette FILE NO. 109084
ST. _____ DATE OF BIRTH Jan 9 1923
COUNTY payette SEX OF CHILD Male
FATHER Ozias Matthews MOTHER Esther May Barker
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Please turn to back Stillborn

Oz. Matthews
Signature of Father or Mother

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named matter. I am sorry to hear that you are not satisfied with the result of the investigation. I have been very anxious to see that the matter is properly handled, and I have been very careful to see that the same is done in accordance with the law. I have been very careful to see that the same is done in accordance with the law. I have been very careful to see that the same is done in accordance with the law.

I am sorry to hear that you are not satisfied with the result of the investigation. I have been very anxious to see that the matter is properly handled, and I have been very careful to see that the same is done in accordance with the law. I have been very careful to see that the same is done in accordance with the law. I have been very careful to see that the same is done in accordance with the law.

I am sorry to hear that you are not satisfied with the result of the investigation. I have been very anxious to see that the matter is properly handled, and I have been very careful to see that the same is done in accordance with the law. I have been very careful to see that the same is done in accordance with the law. I have been very careful to see that the same is done in accordance with the law.

I am sorry to hear that you are not satisfied with the result of the investigation. I have been very anxious to see that the matter is properly handled, and I have been very careful to see that the same is done in accordance with the law. I have been very careful to see that the same is done in accordance with the law. I have been very careful to see that the same is done in accordance with the law.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

796-104-001-466
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Ada

City of _____

No. _____ District No. 7

File No. 109212

Hospital _____ Primary Registration District No. 2006

Registered No. _____

FULL NAME OF CHILD

Baby Proesch

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>_____</u> { and { Number in order of birth <u>_____</u>	Legitimate? <u>Yes</u>	Date of birth <u>Feb 4</u> 192 <u>3</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Ernest John Proesch
RESIDENCE Melba, Ida
COLOR White AGE AT LAST BIRTHDAY 47 (Years)
BIRTHPLACE Minnesota
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Hannah Josephine Moon
RESIDENCE Melba, Ida
COLOR White AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Minnesota
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

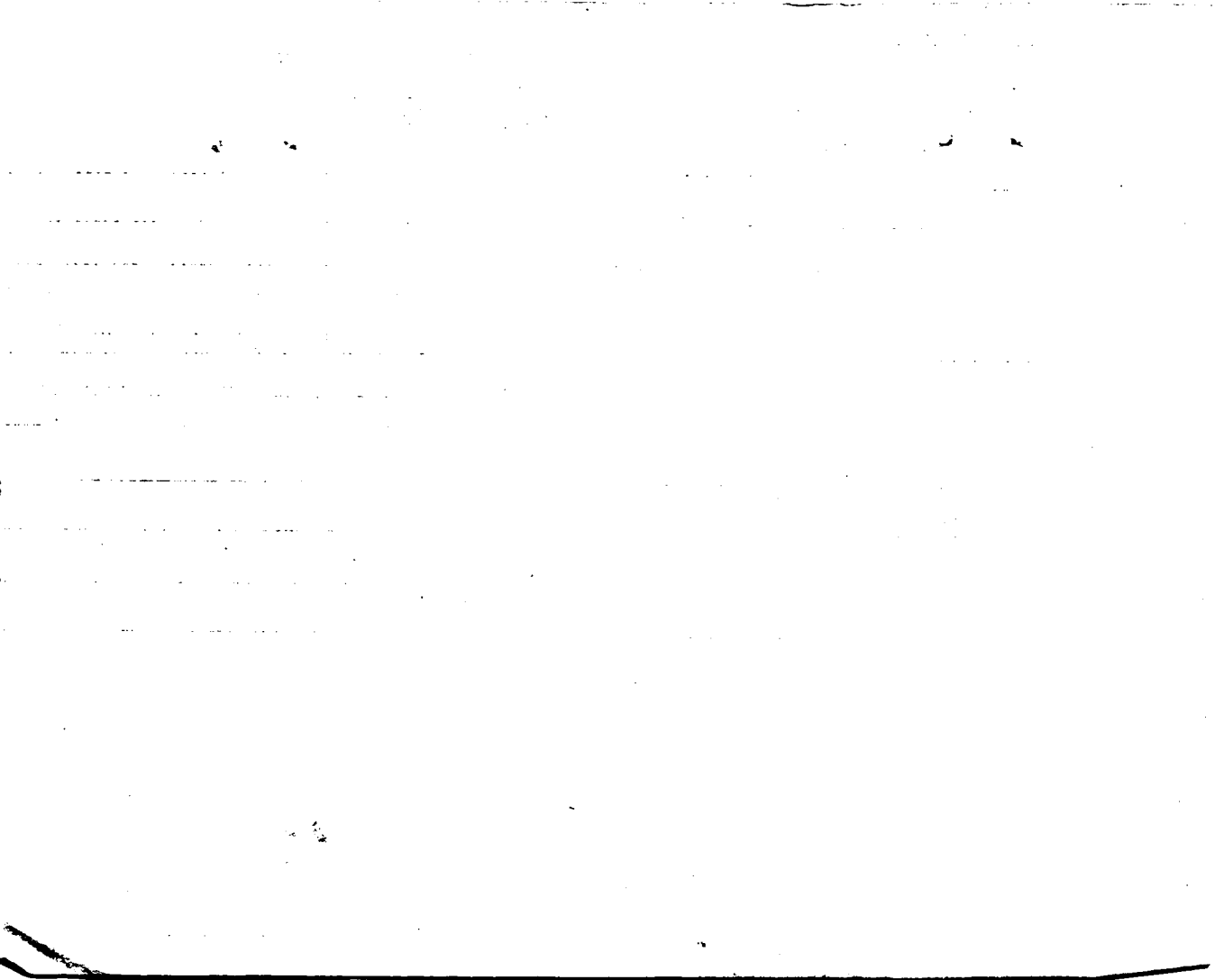
I hereby certify that I attended the birth of this child, who was still born at 11:50 A. M.
on the date above stated. (Born alive or still born)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Samuel A. Swanberg
Melba, Ida
(Physician or midwife)

Give names added from a supplemental report.

Address _____
Filed Mar 6 1923 Pearl Dodds
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
MAY 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41179**

1. PLACE OF DEATH

County of Ada
City of —

Registration District No. 7
Registration District No. 2006
City of — (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Proesch

Registered No. —

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH February 4 1923
(Month) (Day) (Year)

7. AGE 2 Yrs. — Mos. — ds. IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE Ada Co., Idaho
(State or Country)

10. NAME OF FATHER Earnest John Proesch

11. BIRTHPLACE OF FATHER Minnesota
(State or Country)

12. MAIDEN NAME OF MOTHER Hannah Josephine Moon

13. BIRTHPLACE OF MOTHER Minnesota
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Proesch
(Address) Malba

15. Filed Mar. 5 1923 Ida Pearl Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 4 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1923, to Feb 4 1923, that I last saw him alive on Feb 4 1923 and that death occurred on the date stated above, at 11:50 M.

The CAUSE OF DEATH* was as follows:
Still-born. 7 1/2 mo. intra-uterine gestation. Post mortem Caesarian section.

(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) mother died of flu
(Duration) — yrs. — mos. — ds.
(Signed) Samuel A. Swartz M. D.
19 — (Address) Malba, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL Malba DATE OF BURIAL 2/6 1923

20. UNDERTAKER — ADDRESS —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name or organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

593-116-003 815-1
PLACE OF BIRTH

RECEIVED
APR 10 1923
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

109330

County of Bannock
City of Bruxon
No. _____ St. _____
Hospital _____
Registration District No. 2161 File No. _____
Primary Registration District No. 81 Registered No. _____

FULL NAME OF CHILD Benny Miles
(Certificate of no value without full name of child.)

Sex of Child <u>m.</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>3-16</u> 192 <u>3</u> (Month) (Day) (Year)
------------------------	---	-----------	--------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 11 Number of child of this mother now living, including present birth 8

FULL NAME <u>Chas. E. Miles</u>	FATHER	FULL MAIDEN NAME <u>Margaret Hansen</u>	MOTHER
RESIDENCE <u>Bruxon</u>		RESIDENCE <u>Bruxon</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Hogan Utah</u>		BIRTHPLACE <u>Hogan Utah</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Her.</u>	

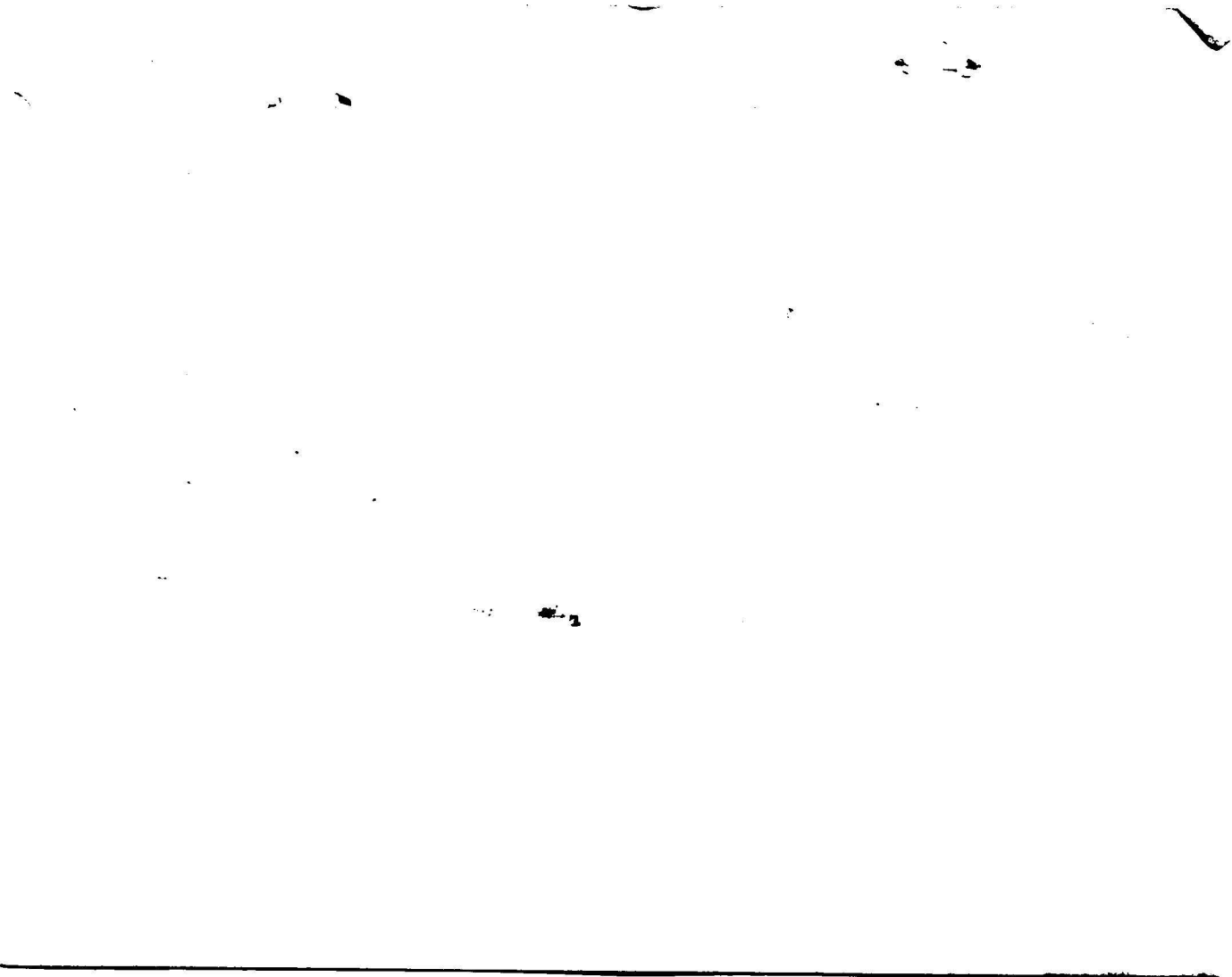
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 5:10 P. M.
on the date above stated. (Born alive or stillborn)

(Signature) Walter Earl H. B.
(Physician or midwife)

Give names added from a supplemental report. _____, 19____
_____, 19____
_____, 19____

Address Barnett Ida
Filed 4-1 1923 W. Earl
Registrar. Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

41354

1. PLACE OF DEATH

County of Bonneville
City of BruxonRegistration District No. 216Primary Registration District No. 84

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Beth Miles

File No. _____

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

3-16-1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bruxon Idaho

10. NAME OF FATHER

Charles E. Miles

11. BIRTHPLACE OF FATHER

(State or Country)

Hyam Utah

12. MAIDEN NAME OF MOTHER

Margaret Hanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Hyam Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 4-1 19 23 W. B. Buch
Local RegistrarMEDICAL CERTIFICATE OF DEATH 151-a

16. DATE OF DEATH

3-16-1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw h. alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia, still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. B. Buch M. D.
3-16-1923 (Address) Bruxon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

815-202-006-819
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham **RECEIVED**
City of Blackfoot **MAR 8 1923** **CERTIFICATE OF BIRTH** **109391**
No. R 274 St. 121 File No. _____
Hospital _____ Primary Registration District No. 2194 Registered No. 72
FULL NAME OF CHILD Sarah Hansen
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>Yes</u> and <u>Yes</u> Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Sec 4</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	--	------------------------	---

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 25 Number of child of this mother now living, including present birth... 3

FATHER		MOTHER	
FULL NAME	<u>Daniel Hansen</u>	FULL MAIDEN NAME	<u>Sarah Harmon</u>
RESIDENCE	<u>Blackfoot</u>	RESIDENCE	<u>Blackfoot</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Farming</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Elston at 7 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. W. Beck

(Physician or midwife)

Give names added from a supplemental report.

Address Blackfoot, Idaho
Filed Mar. 6 1923 Mr. Walter E. Valrie Registrar.

Registrar.

STATE

RECEIVED
APR 20 1923
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 4/14 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY <u>Blackfoot.</u>	FILE NO. <u>109391</u>
	(ST. <u>R.O. 2 Box 64</u>	DATE OF BIRTH <u>Feb. 2 1923</u>
	(COUNTY <u>Bingham</u>	SEX OF CHILD <u>Female</u>
	FATHER <u>Daniel Hansen</u>	MOTHER <u>Sarah M. Harman</u> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Sarah Hansen

Daniel Hansen

Signature of Father or Mother

1. The first part of the report

2. The second part of the report

3. The third part of the report

4. The fourth part of the report

5. The fifth part of the report

6. The sixth part of the report

7. The seventh part of the report

8. The eighth part of the report

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41249**

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

RECEIVED
MAR 8 1923

BUREAU OF VITAL
STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn (Hansen)

Registered No. 15

If death occurred in a hospital institution or camp, its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

189-6

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

(Write the word.)

6. DATE OF BIRTH

Feb 4 1923
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Daniel Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Sarah M. Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel Hansen

(Address)

Blackfoot R. D. 2

15.

Filed

Feb 3 1923 Ms Helen E. Palmer
Local Registrar

16. DATE OF DEATH

Feb 2, 1923
Stillborn
(Month) (Day) (Year)
Had been dead several days

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn
could not determine cause
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Deck M. D.

1/3 1923 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas P. Pinner

Feb 3 1923

20. UNDERTAKER

ADDRESS

Daniel Hansen

Blackfoot

Renton

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

455-227-006-259

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

S

County of Campan RECEIVE

CERTIFICATE OF BIRTH

City of Blackfoot MAR 5 1923

Registration District No. 121

File No. 109418

No. 380 N. Pacific ST. STATISTICS

Primary Registration District No. 1007

Registered No. 64

Hospital

FULL NAME OF CHILD Unnamed Henrich

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate <u>Yes</u>	Date of Birth <u>Feb 27</u> 19 <u>23</u> (Month) (Day) (Year)
----------------------------	---	-----	---	------------------------------	--

FULL NAME FATHER Lao Henrich
RESIDENCE Blackfoot Idaho
COLOR White AGE AT LAST BIRTHDAY 45 (Years)
BIRTHPLACE Austria
OCCUPATION Householder

FULL MAIDEN NAME MOTHER Mary Bernat
RESIDENCE do
COLOR White AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Austria
OCCUPATION Housewife

WHAT BACTERICIDAL SOLUTION WAS USED IN EVERY Carbolic acid
Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4 AM
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

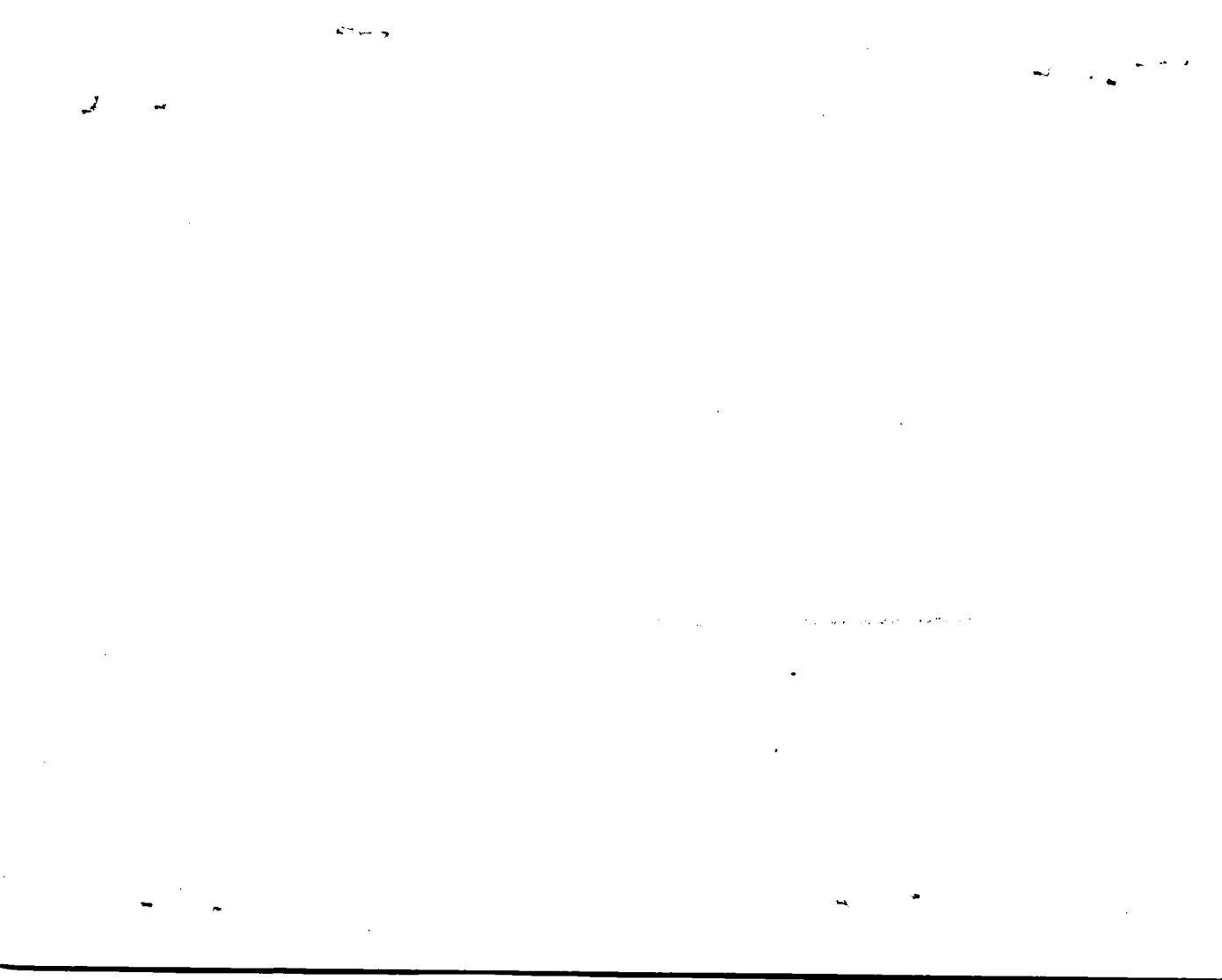
(Signature) M. E. Patric MD.

(Physician or midwife)

Given names added from a supplemental report.

Address Blackfoot Idaho
Filed Mar 5 1923 Mr. Halton E. Patric
Registrar

Registrar



DEPARTMENT OF PUBLIC WELFARE.

Dear Madam:

BUREAU OF VITAL STATISTICS.

* * * * *

FILE NO. 109418
DATE OF BIRTH Feb 1923
SEX OF CHILD Female
MOTHER Mary Bernat
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Still born

Leo Henrich
Signature of Father or Mother.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
41257

1. PLACE OF DEATH
County of Bingham Registration District No. 121
City of Blackfoot Primary Registration District No. 1007
City of Blackfoot West Pacific St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Female

File No. 41257
Registered No. 27
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Feb 27 1923
(Month) (Day) (Year)

7. AGE 1 Yrs. 1 Mos. 1 ds. 1
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION none
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Blackfoot
(State or Country)

10. NAME OF FATHER Leo Henrich

11. BIRTHPLACE OF FATHER Bohemia
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Barnard

13. BIRTHPLACE OF MOTHER Bohemia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo Henrich
(Address) Blackfoot Idaho

15. Filed Feb 28 1923 Wm. H. Allen & Co.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 27 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27 1923 to Feb 27 1923
that I last saw her alive on Stillborn 19.23
and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:
Stillborn - premature 8 mos.

(Duration) Yrs. mos. ds.
Contributory (Secondary) Quick Presentation
(Duration) Yrs. mos. ds.
(Signed) W. E. Patric M. D.
2/27 1923 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wm. H. Allen & Co. B DATE OF BURIAL 2-28 1923
20. UNDERTAKER E. J. Runk ADDRESS Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

123-105,006-165
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Boyer APR 7 1923
City of Blackfoot BUREAU OF VITAL STATISTICS
No. _____ St. _____ Registration District No. 121 File No. 109433
Hospital _____ Primary Registration District No. 2124 Registered No. 91
FULL NAME OF CHILD unnamed abler
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ { and } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>3/5</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 3 ... Number of child of this mother now living, including present birth... 2 ...

FATHER		MOTHER	
FULL NAME <u>Ernest G. Abler</u>	FULL MAIDEN NAME <u>Nicholas Jones</u>		
RESIDENCE <u>Blackfoot 5d4</u>	RESIDENCE <u>Blackfoot 5d4</u>		
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>29</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)		
BIRTHPLACE <u>Kolo</u>	BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 10:15 A. M. on the date above stated. (Born alive or stillborn)

{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. O. Humphreys
(Physician or midwife)
Address Blackfoot, Id 43
Filed April 15 1923 Mrs Helen E. Vatter
Registrar.

Registrar.

SECRET

12

— 148 —

Primary Registration District No. 2

~~CONFIDENTIAL~~

NAME, NAME OF CHILD

(This is a preliminary report of the Committee)

COX	to state the house	to state the house	admission tabular disid to	one	to state the house	to state the house
-----	--------------------------	--------------------------	----------------------------------	-----	--------------------------	--------------------------

See the new mailing label on the back of the envelope.

STANDARD OF THIS MATTER NOW BEING

FBIHQ

1998

MOTHER

TRAJ 1000

知照

WALTER
WAGNER

● 中国书画函授大学肇庆分校

SECRET

NOI 1200

SECRET

CERTIFICATE OF ATTENDING PHYSICIAN OF MARY

14

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-19-2006 BY 60322 UCBAW

Sample:

RESISTANCE

ਪ੍ਰਸੰਨ

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham
City of Springdale

Registration District No. 121
Primary Registration District No. 2194

File No. **41231**Registered No. 32

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME Erven J. Abler

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

msk 5 1923
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)...

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Erven J. Abler
Pinquee, Idaho

15. Filed

Mar 5 1923Mo. H. E. Patrice

Local Registrar

16. DATE OF DEATH

msk 5 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

msk 5 1923 to 191

that I last saw h..... alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

still born
8 mos.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. O. Humphreys M. D.

215 1923 (Address) Starlight Ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas - RiversideMar 6 1923

20. UNDERTAKER

ADDRESS

Erven J. AblerPinquee, Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

957-131 006 415

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED
STATE OF IDAHO
BUREAU OF VITAL STATISTICS
APR 7 1923
BUREAU OF VITAL
STATISTICS
Register No. 121

S

File No. 109447

County of BinghamCity of BlackfootNo. Brooklyn Bldg St.Primary Registration District No. 1007 Registered No. _____

Hospital _____

FULL NAME OF CHILD Unnamed Ingram

Sex of Child <u>male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>March 31</u> 1923 (Month) (Day) (Year)
--------------------------	------------------------------	-----------	--------------------------------	------------------------	--

FATHER
FULL NAME Orthell C. Ingram
RESIDENCE Blackfoot, Idaho
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Idaho
OCCUPATION Cook

MOTHER
FULL MAIDEN NAME Mrs. Davis
RESIDENCE Blackfoot, Idaho
COLOR White AGE AT LAST BIRTHDAY 18 (Years)
BIRTHPLACE N. C.
OCCUPATION Housewife

WHAT ANTISEPTIC SOLUTION WAS USED _____
Number of child of this mother, including present birth _____ Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 11 P.-M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G. W. Mitchell

(Physician or midwife)

Given names added from a supplemental report.

19

Address _____

Filed April 5 1923 Mrs. Walter E. Patis

Registrar

Registrar

MARGIN RESERVED FOR BINDING.
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THE
STANDARD

THE
STANDARD
PUBLISHED
DAILY
EXCEPT
SUNDAY
AND
HOLIDAYS
BY
THE
STANDARD
PUBLISHING
CO.
100 N. 3RD ST.
ST. LOUIS, MO.
1900

1. PLACE OF DEATH

County of Bingham Registration District No. 131
 City of Blackfoot Primary Registration District No. 1007
Bureau of Vital Statistics (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

unnamed Ingram

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 41241

Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

March 31 1923
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds. IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Blackfoot, Idaho

10. NAME OF FATHER

Arthur C. Ingram

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mrs. Davis

13. BIRTHPLACE OF MOTHER

(State or Country) N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Ingram
 (Address) Blackfoot Idaho.

15. Filed March 31 1923 Mrs. Helen E. Pattee
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 31 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1923 to March 31 1923, that I last saw him live on March 31 1923 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Prima facie death
 (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
 (Signed) G. W. McIntosh M. D.
31 1923 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Blackfoot Idaho 19
 20. UNDERTAKER G. J. Beck ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement, it should be used only when necessary. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

964-101-010704 father & Mother's names amended 5/4/2004tlc
child's name added 5/4/2004tlc

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

County of Bonneville

City of Lona

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD Roy Edmund Rounds

RECEIVED STATE OF IDAHO
BUREAU OF VITAL STATISTICS
MAR 8 1923
BUREAU OF VITAL STATISTICS
REGISTRATION DISTRICT NO. 73 File No. 109567

Primary Registration District No. 2190 Registered No. 141

Sex of Child <u>Male</u>	Twin Triplet or other? <u>2</u> (To be answered only in event of plural births)	and { Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>Feb 1</u> (Month) (Day) (Year) <u>1923</u>
--------------------------	--	--------------------------------------	----------------------------	--

FULL NAME <u>Ambrose Edmund</u> <u>Lambert</u> FATHER	FULL MAIDEN NAME <u>Margaret Ethe</u> <u>Godfrey</u> MOTHER
RESIDENCE <u>Lona</u>	RESIDENCE <u>Lona</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Lona</u>	BIRTHPLACE <u>Garfield Idaho</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>House Wife</u>

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

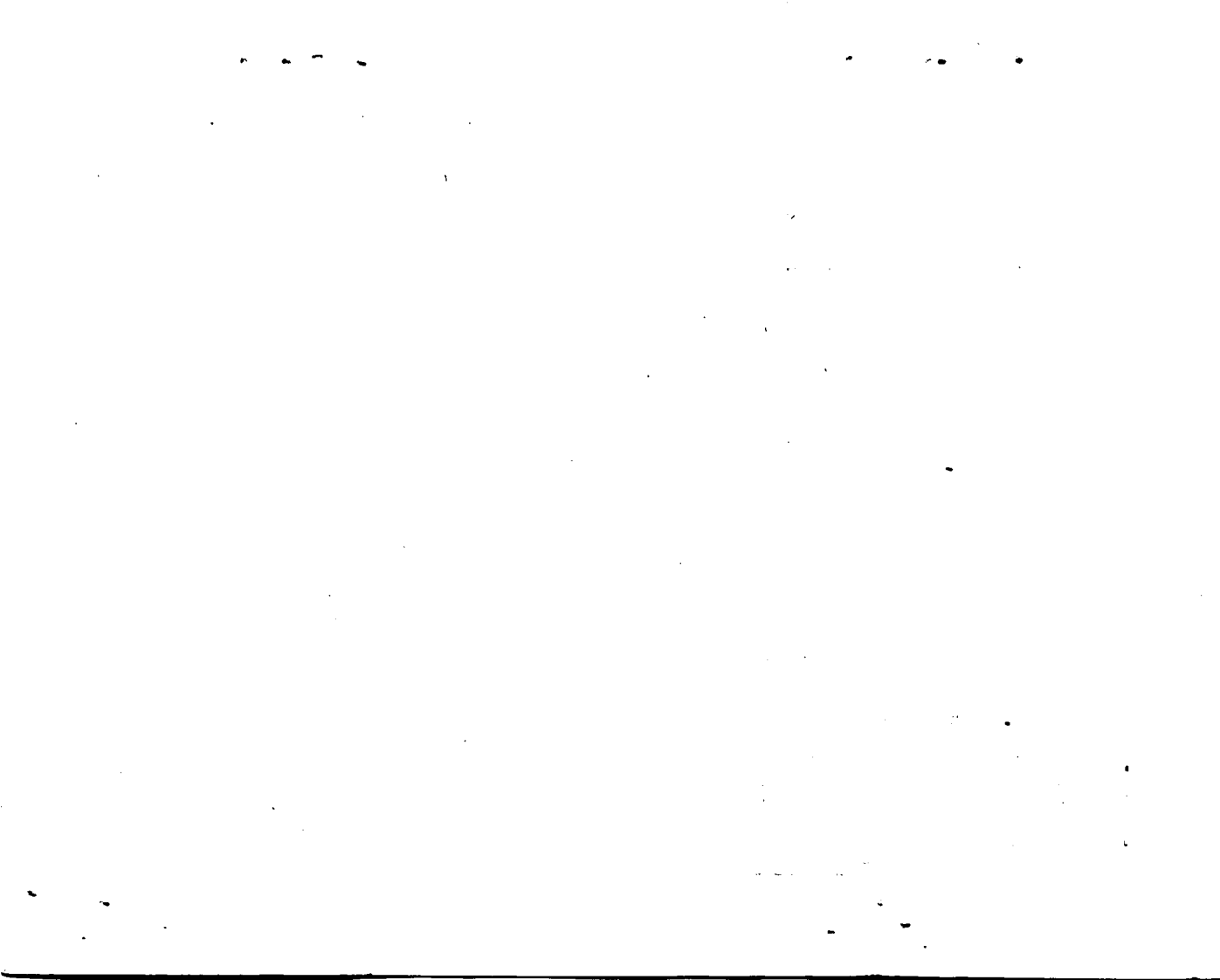
I hereby certify that I attended the birth of this child, who was Child born at 2 45 a.m.
on the date above stated. (Born alive or stillborn)

(Signature) Mary Godfrey Stoddard
Minister
(Registered or midwife)

Given names added from a supplemental report. _____ 19 _____

Address Bigby Idaho

Filed Feb 11 - 1923 W. E. Fennell
Registrar Registrar



State of Idaho }
County of Jefferson } SS

Certificate No. 23-109567
Date Filed March 8, 1923

The undersigned does solemnly swear that certain facts on the certificate of birth (Birth, Death, Marriage, etc.)
for unnamed Rounds who was born on February 1, 1923
(Name on Original Certificate) (Was Born, Died, etc.) (Date of Event)

in <u>Iona (Bonneville Co.)</u> (Place of Event)	are erroneous or were omitted.
---	--------------------------------

ITEMS TO BE CORRECTED

FROM

TO

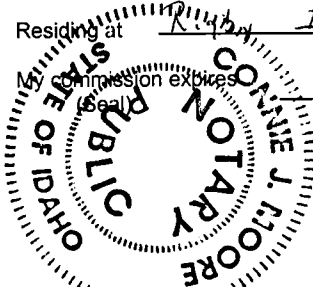
Child name	<u>unnamed</u>	<u>Roy Edmund Rounds</u>
Father's name	<u>Ambros</u>	<u>Ambrose Edmund</u>
Mother's name	<u>Margret E.</u>	<u>Margaret Ethel</u>

Subscribed and sworn to before me this 27 day of

Notary Public, Connie J. Moore

Residing at R. 4th Id.

My commission expires 7-8-06
(Seal)



April 2004
Roy E. Rounds
Signature of Applicant

4024 E 145th N Idaho Falls, Id
Street Address, City, State and Zip 83401

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ }
County of _____ } SS

(Must be completed ☐)

(Is not necessary ☒)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____

Notary Public, _____

Residing at _____

My commission expires _____
(Seal)

Signature of Applicant

Street Address, City, State and Zip

SOCIAL SECURITY HEALTH INS. CARD GIVES NAME AS ROY E. ROUNDS. ISSUED 1-1-1988
VIEWED BY VS #1975-05831.

MOTHER'S IDAHO DEATH CERTIFI GIVES NAME AS MARGARET ETHEL ROUNDS WHO DIED
NOV. 19, 1975 IN IDAHO FALLS, IDAHO. VIEWED BY VS

BROTHER'S IDAHO BIRTH CERTIFICATE GIVES NAME AS JERRY AMBROSE ROUNDS #1932-206968
BORN OCT. 22, 1932 IN RIGBY, IDAHO. MOTHER'S NAME GIVEN AS MARGARET ETHEL GODFREY AND
FATHER'S NAME AS AMBROSE EDMUND ROUNDS. VIEWED BY VS

DAUGHTER'S BIRTH CERTIF. FROM IDAHO #1952-8776 GIVES NAME AS SANDRA ROUNDS, BORN
JUNE 25, 1952 IN RIGBY, IDAHO. MOTHER'S NAME GIVEN AS NORMA SELLERS AND FATHER'S
NAME AS ROY EDMUND ROUNDS. VIEWED BY VS

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

497 107 011 497
PLACE OF BIRTH

RECEIVED
MAR 26 1923

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S

109615

County of Boundary

City of Bonners Ferry

BUREAU OF VITAL STATISTICS
Registration District No. 29

File No. 109615

No. _____ St. _____

Hospital Bonners Ferry Primary Registration District No. 2156

Registered No. _____

FULL NAME OF CHILD

Titus Migaki

Sex of Child male

Twin
Triplet
or other?

and { Number in order of birth 2 }

Legitimacy? yes

Date of Birth Feb. 7 1923
(Month) (Day) (Year)

FULL NAME

FATHER Kindachi Migaki

FULL MAIDEN NAME

MOTHER Hisano Migaki

RESIDENCE

Bonners Ferry

RESIDENCE

Bonners Ferry

COLOR

yellow

AGE AT LAST BIRTHDAY

34
(Years)

COLOR

yellow

AGE AT LAST BIRTHDAY

27
(Years)

BIRTHPLACE

Japan

BIRTHPLACE

Japan

OCCUPATION

Laundryman
what bactericidal solution was used in eyes?

OCCUPATION

Housewife
120 Ag 403

Number of child of this mother, including present birth _____

Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Stillborn, at 6 A. M.
(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. E. Fry
Physician
(Physician or midwife)

Given names added from a supplemental report.

19 _____

Address

Bonners Ferry, Ida.

Filed

2/28/1923

Registrar

Registrar

MADE IN KANSAS FOR BIRMINGHAM

THIS IS A CERTIFICATE OF BIRTH FOR A CHILD BORN IN THE CITY OF KANSAS, AND IS VALID FOR THE PURPOSES OF THE KANSAS CIVIL SERVICE COMMISSION. IT IS NOT VALID FOR THE PURPOSES OF THE KANSAS CIVIL SERVICE COMMISSION IF THE CHILD IS NOT A NATURAL BORN CITIZEN OF THE UNITED STATES.

Given notice which from a supplemental report.
10.
Registrar
Filed
10 23

When there was no attending physician or midwife, then the father, home doctor, or other person who attended the birth of the child is to be named. A child born in the home of the father, mother, or other person is to be named as such.

CERTIFICATE OF BIRTH

FULL NAME OF CHILD		HOSPITAL	
NAME	RESIDENCE	NAME	RESIDENCE
FATHER	MOTHER	DATE OF BIRTH	DATE OF BIRTH
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	COLOR	COLOR
BIRTHPLACE	BIRTHPLACE	OCCUPATION	OCCUPATION
Number of child of this mother, including present birth			
Number of children of this mother now living, including present birth			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE			
I hereby certify that I attended the birth of this child, who was born alive or stillborn.			
(Physician or midwife)			

10 23

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Boundary*
City of *Bonner Ferry*Registration District No. *79*Primary District No. *2156*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Migaki*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **41283**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb. 7th 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. da.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Kinichi Migaki

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Hisano Migaki

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

SSM
Bonner Ferry, Ida

15.

Filed

21 9 1923

Local Registrar

16. DATE OF DEATH

Feb. 7th 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Stillborn
(a twin - prolapsed cord
pressed upon by older twin)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

SSM M. D.
21 9 23 (Address) *Bonner Ferry*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Bonner Ferry**21 7 1923*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

493-226 214-394
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

MAR 8 1923

CERTIFICATE OF BIRTH

County of Canyon

City of Nampa

No. 1312-4th St. S.

BUREAU OF VITAL
STATISTICS

Registration District No. 7

File No. 109622

Hospital Mercy

Primary Registration District No. 1006

Registered No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Feb. 26</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? Silver Nitrate 1.0% Sol.

Number of child of this mother, including present birth... 2 ... Number of child of this mother now living, including present birth... 1 ...

FULL NAME <u>Marrin M. Miller</u>	FATHER
RESIDENCE <u>Nampa - Idaho.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Iowa.</u>	
OCCUPATION <u>Ry. Fireman</u>	

FULL MAIDEN NAME <u>Hazel Trumball</u>	MOTHER
RESIDENCE <u>Nampa - Idaho.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Nebraska.</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... still born ... at... 11 P. ... M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Geo. R. Proctor
Physician.
(Physician or midwife)

Give names added from a supplemental report.

_____, 19____

Registrar.

Address

Filed Mar. 5 1923 Pearle Dodds
Registrar.

100-100000

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41312**

1. PLACE OF DEATH

County of Canyon
City of NashuaRegistration District No. 7BUREAU OF VITAL STATISTICS
Primary Registration District No. 1006
(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white

(Write the word.)

6. DATE OF BIRTH

Feb 26 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)✓

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

M. M. Miller

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Agnes Trumbull

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. M. Trumbull

(Address)

Caldwell #3

15.

Filed Mar. 5 1923Pearl Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

1898

16. DATE OF DEATH

About Feb 24 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:Still born - pre-natal
cause

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Geo. R. Proctor M. D.

..... 19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Koklesburg Cem

DATE OF BURIAL

2-28-1923

20. UNDERTAKER

J. K. Robinson

ADDRESS

Nashua

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

392-108-014-255
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

MAR 14 1923

CERTIFICATE OF BIRTH

109639

County of Canyon

City of Caldwell

No. Route 3

BUREAU OF VITAL
STATISTICS

Registration District No. 3

File No. _____

Hospital _____

Primary Registration District No. 2005

Registered No. 38

FULL NAME OF CHILD

Baby Tish

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>/</u>	and	Number in order of birth <u>1</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>Mar 8</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER
FULL NAME Ray Joel
RESIDENCE Caldwell
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Nebraska
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Hazel Bennett
RESIDENCE Caldwell
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Nebraska
OCCUPATION Homemaker

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 30 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

R. G. Young, M.D.

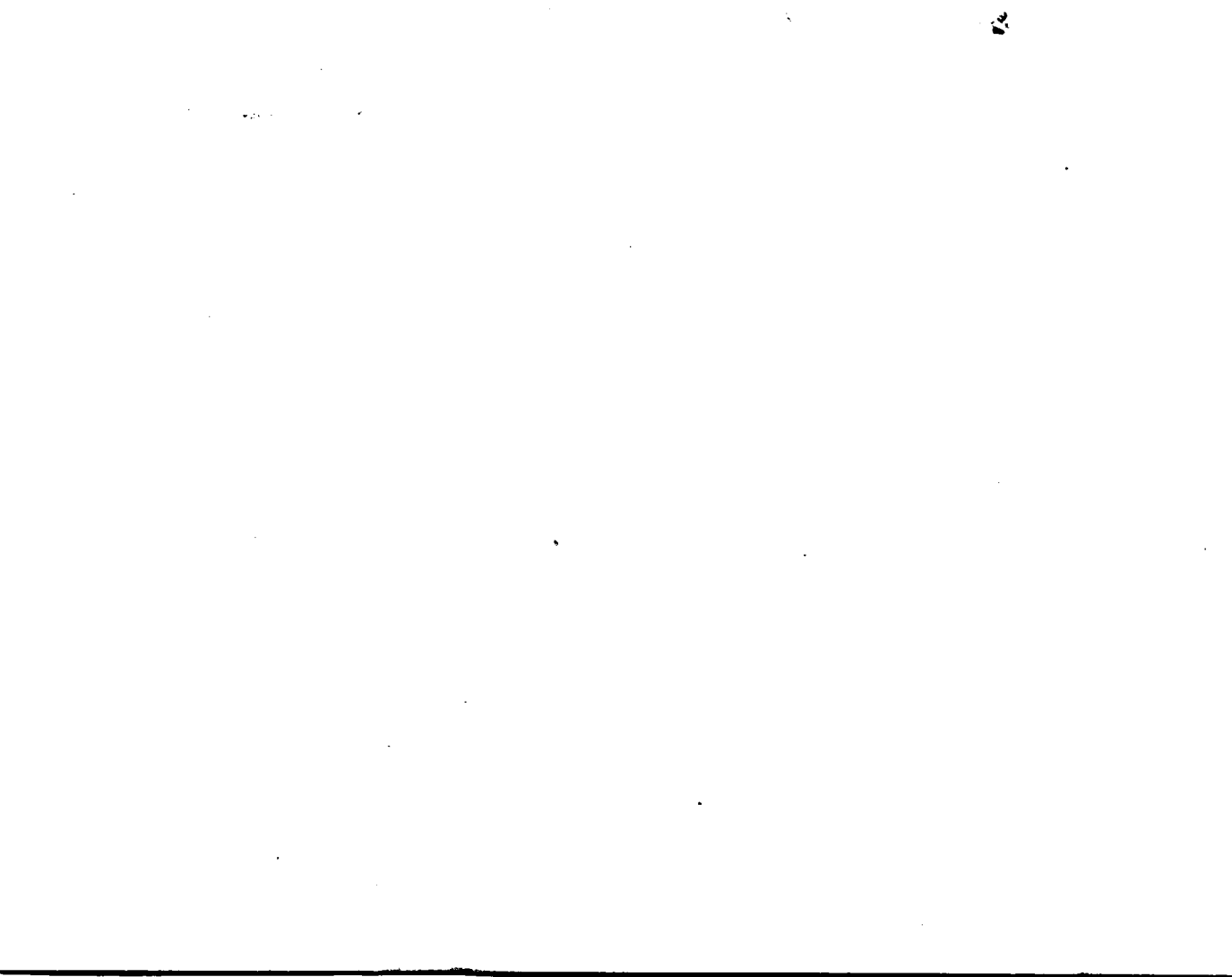
(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed

Mar 9 1923 John L. Mayes
Registrar.



255-108-014-319

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

APR 5 1923

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of CanyonBUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

S

City of nampaRegistration District No. 7File No. 109695

No. _____ St. _____

Hospital _____

Primary Registration District No. 2086 Registered No. _____

FULL NAME OF CHILD

Caused by over work while moving from country - 7 monthsSex of Child maleTwin
Triplet
or other?
(To be answered only in event of plural births)Number
in order
of birth
(To be answered only in event of plural births)Legiti
mate?Date of
BirthFeb 8

(Month) (Day)

1923
(Year)FULL
NAMEC. L. Bever

FATHER

FULL
MAIDEN
NAMEB. E. Barton

MOTHER

RESIDENCE

nampa Ida

RESIDENCE

nampa Ida

COLOR

whiteAGE AT LAST
BIRTHDAY42
(Years)

COLOR

whiteAGE AT LAST
BIRTHDAY36
(Years)

BIRTHPLACE

Nab.

BIRTHPLACE

Virginia

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Dead born, at 10³⁰ a. m. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. H. Murray
M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

nampa Idaho

Filed

Apr. 3 1923Pearle Dodge

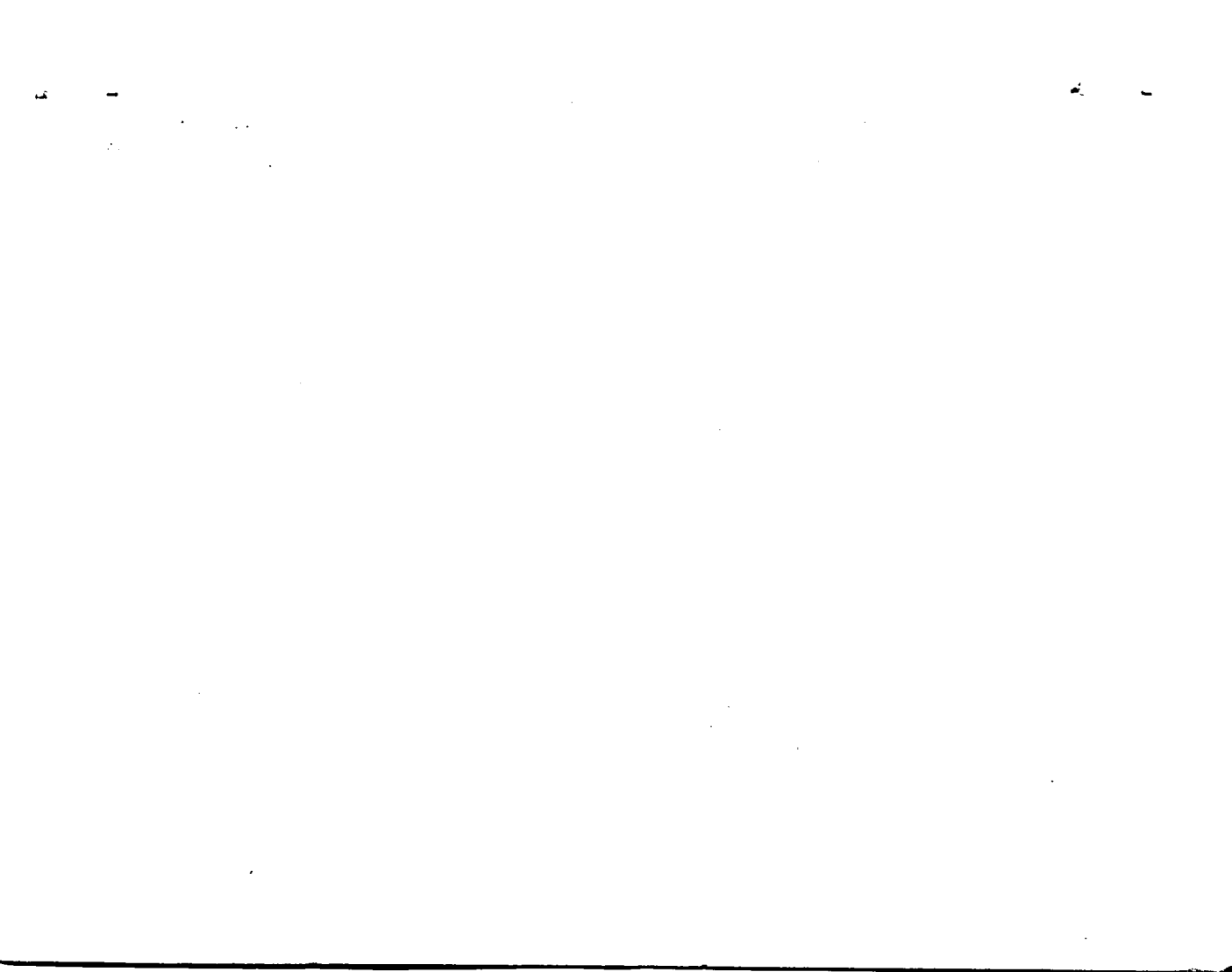
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



REC

APR

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CanyonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Bever

(No. _____, St.)

File No. 41292

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhite

(Write the word.)

6. DATE OF BIRTH

Feb81923

(Month)

(Day)

(Year)

7. AGE

✓

Yrs.

✓

Mos.

✓

ds.

IF LESS than 1 day
how many ✓ hrs.
or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. L. Bever

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

B. E. Lorton

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. L. Bever

(Address)

Nampa, Ida

15.

Filed Mar. 20 1923Pearl D. Dadd

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb81923

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

FEB 81923to FEB 81923

that I last saw him alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Dead born - mother worked too hard at nursing & was exposed to cold.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Murray M. D.2/9/1923(Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Nampa

DATE OF BURIAL

2/8 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

692-123-016364
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Burley

No. _____

St. _____

St. _____

CERTIFICATE OF BIRTH

File No. _____

109713

Hospital _____

Primary Registration District No. _____

2196

Registered No. _____

2485

FULL NAME OF CHILD Charles LeRoy Fisher

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>JAN. 23</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	------------------------------	-----------	--------------------------------	------------------------	---

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth... 0... Number of child of this mother now living, including present birth... 0...

FULL NAME <u>Alvin Fisher</u>	FATHER
RESIDENCE <u>Burley Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Belnap Kansas</u>	
OCCUPATION <u>Laborer</u>	

FULL MAIDEN NAME <u>Florence Tomlinson</u>	MOTHER
RESIDENCE <u>Burley Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Hanibal Mo.</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... Still born... at... 10:40 A. M.
on the date above stated. (Born alive or stillborn)

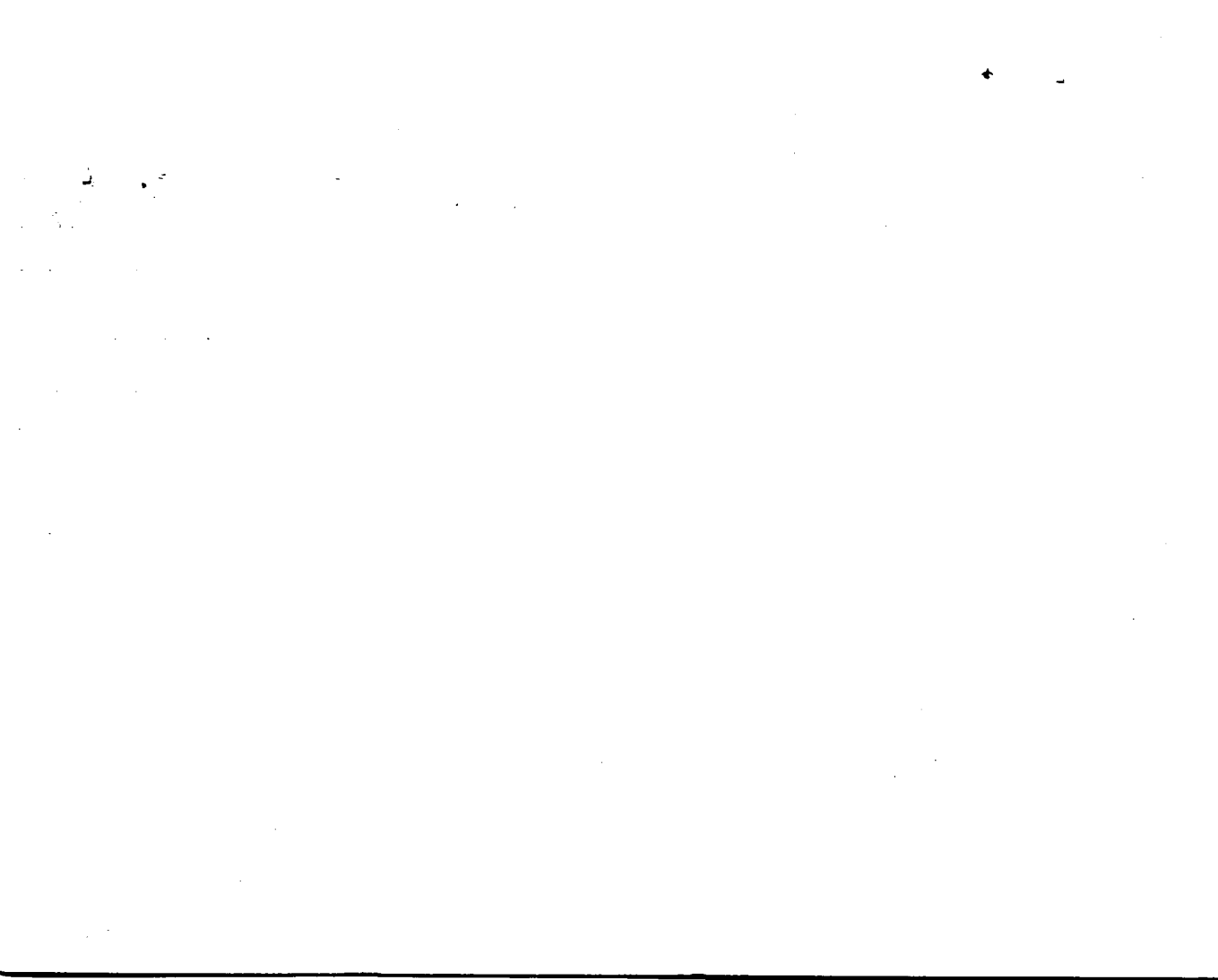
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) B. A. Rich
Physician.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Burley, Idaho
Filed Feb 1 1923 Dr. J. C. Patterson
Registrar.



CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CassiaCity of Burley

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAR 22 1923
BUREAU OF VITALS

Registration District No.

Primary Registration District No.

(City)

(State)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

41325

650

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles LeRoy Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

January 23

(Month)

(Day)

1923

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley Idaho

10. NAME OF FATHER

Alvin Fisher

11. BIRTHPLACE OF FATHER

(State or Country)

Bellevue Kansas

12. MAIDEN NAME OF MOTHER

Florence Tomlinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Hanibal Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alvin Fisher (per C. A. Rich)

(Address)

Burley Idaho. (Copy from birth certificate)

15.

Filed

Jan 31 1923W. J. Patterson
Local RegistrarBy J. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January

(Month)

23

(Day)

1923

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

At delivery 19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Still birth. Failure of respiratory centers.

(Duration) Yrs. mos. ds.

Contributory Chondrodystrophia of mother
(Secondary) causing deformity of pelvis

(Duration) Yrs. mos. ds.

(Signed)

C. A. Rich M. D.1-24-1923 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida

DATE OF BURIAL

1-23-1923

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

395-209 016-294
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia
City of Burley
No. 117 St. BUREAU OF VITAL STATISTICS No. 117
Hospital _____ Primary Registration District No. 2196
FULL NAME OF CHILD Baby Cressell Registered No. 2488
(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? — and — Number in order of birth — Legitimate? Yes Date of birth 1-9 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 3 Number of child of this mother now living, including present birth... 2

FATHER		MOTHER	
FULL NAME	<u>Geo Cressell</u>	FULL MAIDEN NAME	<u>Bora Kidinan</u>
RESIDENCE	<u>Burley</u>	RESIDENCE	<u>Burley</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY (Years)	AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE	<u>Utah</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farming</u>	OCCUPATION	<u>Mother</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still-born at 3²⁰ P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

F. Hentler
M.D.

(Physician or midwife)

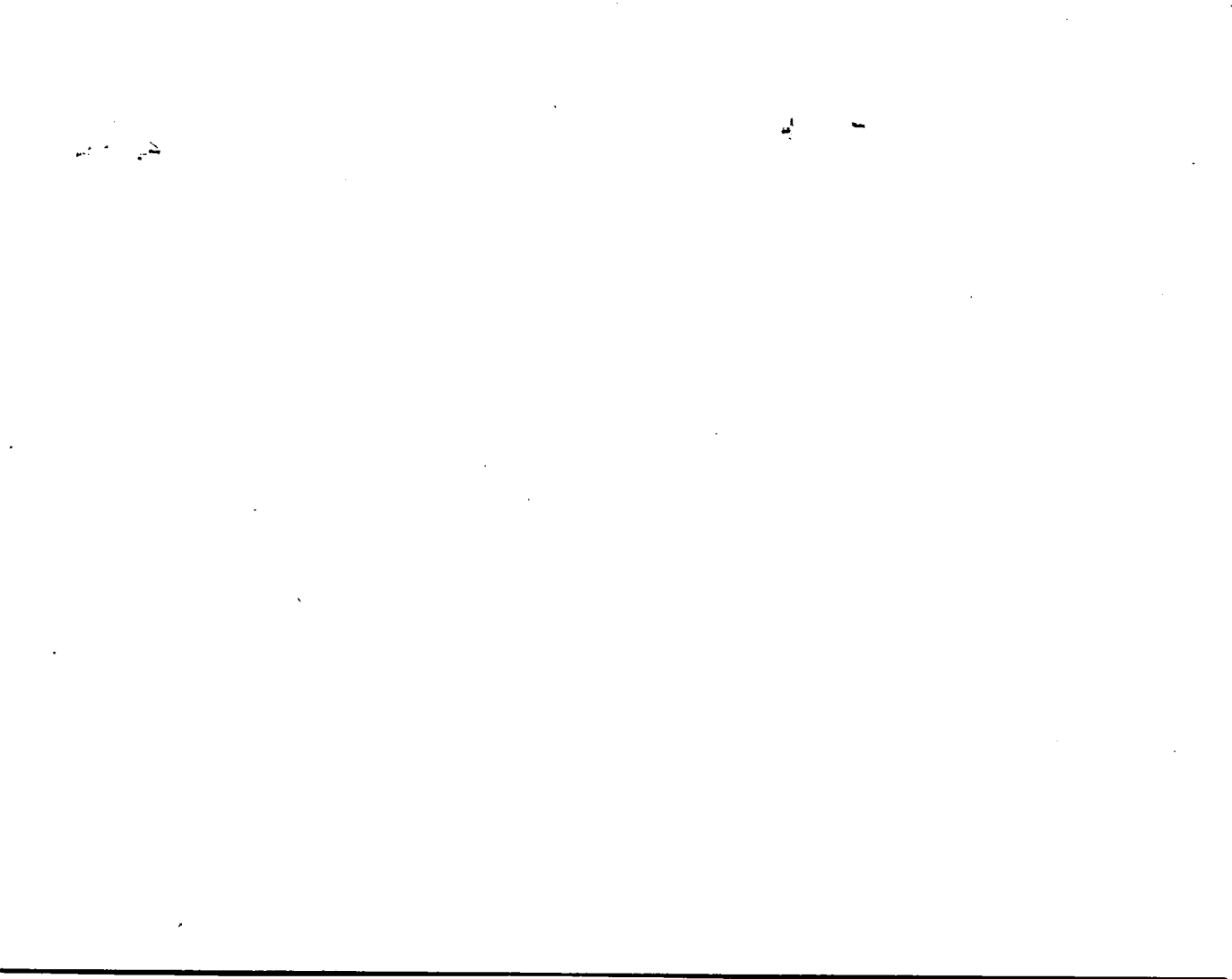
Give names added from a supplemental report.

Address

Burley Ida

Filed

Feb. 1, 1923 D. J. C. Patterson
Registrar.



FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

✓ *Under*
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41327**
Registered No. **652**

1. PLACE OF DEATH

County of *Cassia* Registration District No. *117*
City of *Burley* Primary Registration District No. *2196*
City of *Burley* State # *1* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Cressall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (Write the word.)

6. DATE OF BIRTH

Jan. 9 = 1923
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Burley, Ida.*

10. NAME OF FATHER

George G. Cressall

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

Cora Kidman

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *G. G. Cressall*

(Address) *R. F. D. # One Burley, Ida.*

15.

Filed *Feb. 1* 19*23*

Dr. J. C. Patterson
Local Registrar
By S. C.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 9 = 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 9 19*23* to *Jan 9* 19*23*
that I last saw him alive on *Jan 9* 19*23*

and that death occurred on the date stated above, at *3:25 P.*

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *J. H. Hunter*

M. D.

19 (Address) *Burley*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.

DATE OF BURIAL

Jan. 10 1923

20. UNDERTAKER

L. B. Gregory

ADDRESS

Burley, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each,
and the number of each, in order of birth stated.

512 106-011513

PLACE BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
COUNTY OF Idaho

Form V. S. No. 11-C-25m-7-21-19

County of Idaho

MAR 12 1923

CERTIFICATE OF BIRTH

S

City of Subois

BUREAU OF VITAL STATISTICS

Registration District No.

125

File No.

109746

No. _____ St.

Primary Registration District No. 2203

Registered No.

Hospital _____

Naba

Stillborn

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>Feb 6</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-------------------------------	---

FULL NAME <u>Louis Naba</u>	FATHER
RESIDENCE <u>Subois ID</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Mexico</u>	
OCCUPATION <u>RR Laborer</u>	

FULL MAIDEN NAME <u>Petra Valdez</u>	MOTHER
RESIDENCE <u>Subois ID</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Mexico</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 11:30 a. m.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

W. E. Jones MD
(Physician or midwife)

Given names added from a supplemental report.

Address

Subois Idaho

Filed

Feb 6 1923

W. E. Jones MD
Registrar

Registrar

347801

File No.

Registration District No.

21.

MI

07 b97942431

Primary Registration District No.

IsigeoH

CHILD'S NAME OF CHILD

to x98
blind

FATHER

NAME _____
FOOT _____

REFERENCE

RESIDENCE

BIRTHDAY
AGE AT LAST

COLOR

AGE AT LAST
BIRTHDAY

80 102

BIRTHPLACE

436-1341-019

OCCUPATION

MORTALITY 200

Number of child of this mother, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

(From alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other signs of life after birth.

100-443887-100

საერთაშორისო

bold

Realized

ЗАДАНИЕ

ЖУВОНА СЪЗДАВА ЛОВ ВИННИК

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41332**

1. PLACE OF DEATH

Registration District No. 125
County of Clark RECEIVED
City of Subaw Po MAR 12 1923
Primary Registration District No. 2203
City of _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH Feb 6 1923
(Month) (Day) (Year)

Feb 6 1923
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day
how many _____ hrs.
Yrs. Mos. ds. or min.?

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Stillborn
Premature 6 mos
(Duration) _____ Yrs. mos. ds.

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Contributory (Secondary) _____
(Duration) _____ yrs. mos. ds.
(Signed) GE Jones M. D.
Feb 6 1923 (Address) Subaw Po Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

289-217-020-453
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of ElmoreCity of Elmer's Ferry Idaho

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD

RECEIVED
APR 7 1923
BUREAU OF VITAL
STATISTICS

Primary Registration District No. 35File No. 109764Primary Registration District No. 2021

Registered No. _____

Sex of
ChildFemaleTwin
Triplet
or other?

and

Number
in order
of birth4Legiti-
mate?yesDate of
BirthMarch 191923

(Month)

(Day)

(Year)

FULL
NAME

FATHER

Ralph Byrum

RESIDENCE

Elmer's Ferry Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

23

(Years)

BIRTHPLACE

America

OCCUPATION

Clark Mercantile StoreFULL
MAIDEN
NAME

MOTHER

Myrtle Decker

RESIDENCE

Elmer's Ferry Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

31

(Years)

BIRTHPLACE

America

OCCUPATION

HousewifeNumber of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

March 19 1923 at 2:30 P. M.
(Born alive or stillborn)

(Signature)

J. W. Davis

(Physician or midwife)

Address

Elmer's Ferry Idaho

Filed

March 25 1923

Registrar.

Registrar.

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

Given names added from a supplemental report.

19

the 1990s, the number of people in the world who are illiterate has increased from 1.2 billion to 1.5 billion. The number of illiterate people in the world is projected to reach 1.7 billion by the year 2015. The number of illiterate people in the world is projected to reach 1.7 billion by the year 2015. The number of illiterate people in the world is projected to reach 1.7 billion by the year 2015.

1

•

④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺ ㊻ ㊼ ㊽ ㊾ ㊿

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

Form V. S. No. 5. 10M. 6-20-11. APR 7 1923 CERTIFICATE OF DEATH

1. PLACE OF DEATH **BUREAU OF VITAL STATISTICS** District No. 35
County of Elmore Primary Registration District No. 2021
City of Elmer's Ferry (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41339
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH March 17 1923
(Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day
how many _____ hrs. or
_____ yrs. _____ mos. _____ ds. _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) America

10. NAME OF FATHER

Ralph Byrum

11. BIRTHPLACE OF FATHER

(State or Country) America

12. MAIDEN NAME OF MOTHER

Myrtle Greer

13. BIRTHPLACE OF MOTHER

(State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Myrtle Greer

(Address) Elmer's Ferry Idaho

15.

Filed March 28 1923 J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still Born 191____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 17 1923 to March 17 1923
March 17 1923 to March 17 1923
that I last saw h was dead probably 12 days alive on March 17 1923

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Unknown to me

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Davis M. D.

March 18 1923 (Address) Elmer's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Near King Hill on Ranch

March 18 1923

20. UNDERTAKER

ADDRESS

Ralph Byrum

Elmer's Ferry Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

249 20 023 249
PLACE OF BIRTH

RECEIVED

APR 5 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lem

City of Emmett

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. _____ St. _____

Registration District No. 6

File No. 109878

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD

Unmarried Infant

(Certificate of no value without full name of child.)

Sex of Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

3/20

1923

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth. 1

Number of children of this mother now living, including present birth. 9

FULL
NAME

FATHER

Warner Smith

FULL
MAIDEN
NAME

MOTHER

Bertina May Smith

RESIDENCE

Emmett Rt 2

RESIDENCE

Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

2.1
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

38
(Years)

BIRTHPLACE

Va

BIRTHPLACE

Va

OCCUPATION

Farmer

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was.....

still born

(Born alive or stillborn)

4..... a..... M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. W. Smith

Father

(Physician or midwife)

Give names added from a supplemental report.

Address

Emmett Rt 2

Filed

3/20 1923

J. D. Reynolds

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-1 **RECEIVED** APR 3 1923 **CERTIFICATE OF DEATH.**

1. PLACE OF DEATH **Bureau of Vital Statistics**
County of **Sumner** District No. **6**
City of **Emmett** (No. _____) (St.) _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41379**
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Not named**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Infant**
(Write the word.)
6. DATE OF BIRTH **3/21/1923**
(Month) (Day) (Year)
7. AGE **Still born** IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country) **Emmett Ida**

10. NAME OF FATHER

James Warner Smith

11. BIRTHPLACE OF FATHER

(State or Country) **Va**

12. MAIDEN NAME OF MOTHER

Bertha May Smith

13. BIRTHPLACE OF MOTHER

(State or Country) **Va**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **J W Smith**
(Address) **Emmett Ida #2**

15. Filed **3/20/1923** **J A Reynolds**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Still birth 3/20/23**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191____ to 191____
that I last saw him alive on 191____
and that death occurred on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows:

**Baby was lost at birth
No doctor in attendance**

(Duration) Yrs. mos. ds.
Contributory (Secondary) _____
(Signed) **J A Reynolds** M. D.
3/20/1923 (Address) **Emmett Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Father Buried Child** DATE OF BURIAL **3/21/1923**
20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Jefferson

City of Rigby

No. 693-219-026-165

RECEIVED
MAR 19 1923

CERTIFICATE OF BIRTH

BUREAU OF VITAL
STATISTICS

No. 98

File No.

109965

Hospital

Primary Registration District No.

2176

Registered No.

15

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of
Child

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

1-19

1923

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

4

Number of children of this mother now living, including present birth

2

FATHER
FULL
NAME

Roy P. Fillmore

MOTHER
FULL
NAME

Margaret Jones

RESIDENCE

Rigby

RESIDENCE

Rigby

COLOR

w

AGE AT LAST
BIRTHDAY

35

(Years)

COLOR

w

AGE AT LAST
BIRTHDAY

34

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

at home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

stillborn at 9:50 A. M.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Roy P. Fisher

(Physician or midwife)

Give names added from a supplemental report.

Address

Rigby

Filed

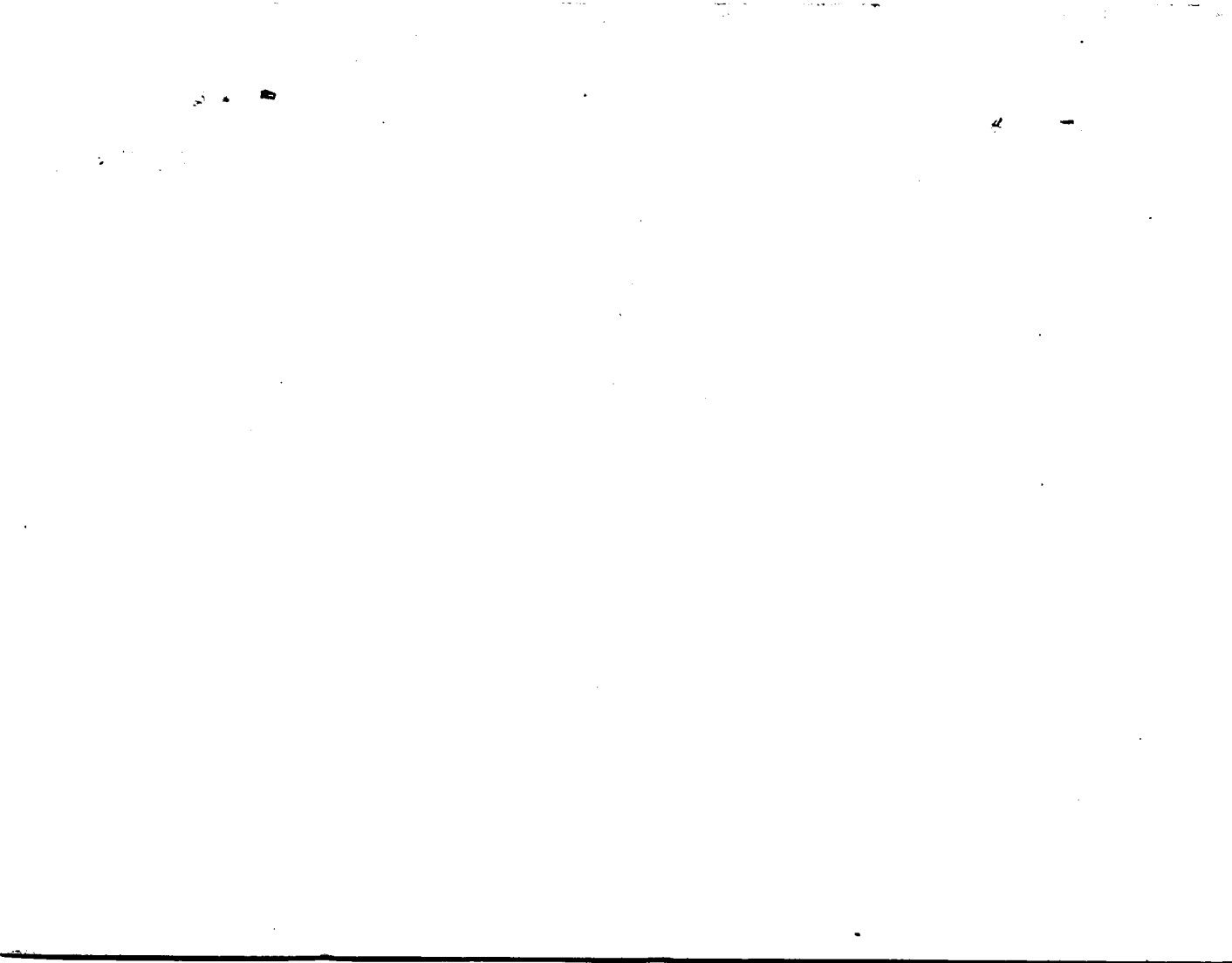
3/10

1923

Roy P. Fisher

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

MAR 14 1923

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

41415

1. PLACE OF DEATH

County of *Jefferson*

City of *Rigby*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 - 19 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

stillborn

(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Ray H. Fisher* M. D.
1-19-23 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Rigby* DATE OF BURIAL *1-19-23*

20. UNDERTAKER ADDRESS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH
1 - 19 1923
(Month) (Day) (Year)

7. AGE
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Infant*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) *Idaho*

10. NAME OF FATHER *Ray L. Fillmore*

11. BIRTHPLACE OF FATHER
(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER *Margaret Jones*

13. BIRTHPLACE OF MOTHER
(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *R. L. Fillmore*
(Address) *Rigby, Idaho*

15. Filled *3/10* 19 *23* *Ray H. Fisher*
Local Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

268 114 030 268

PLACE OF BIRTH

County of Pauline

City of Salmon

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD _____

Sex of Child <u>m.</u>	Twin Triplet or other? <u>no</u> (To be answered only in event of plural births)	and	Number in order of birth <u>1</u>	Legitimate? <u>no</u>	Date of Birth <u>Feb. 14</u> 19 <u>23</u> (Month) (Day) (Year)
------------------------	---	-----	-----------------------------------	-----------------------	---

FATHER
FULL NAME Will not divulge
RESIDENCE _____
COLOR _____ AGE AT LAST BIRTHDAY _____ (Years)
BIRTHPLACE _____
OCCUPATION _____

MOTHER
FULL MAIDEN NAME Oliver Esther Bohannon
RESIDENCE New York
COLOR White AGE AT LAST BIRTHDAY 18 (Years)
BIRTHPLACE Idaho
OCCUPATION house

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn, at Salmon on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

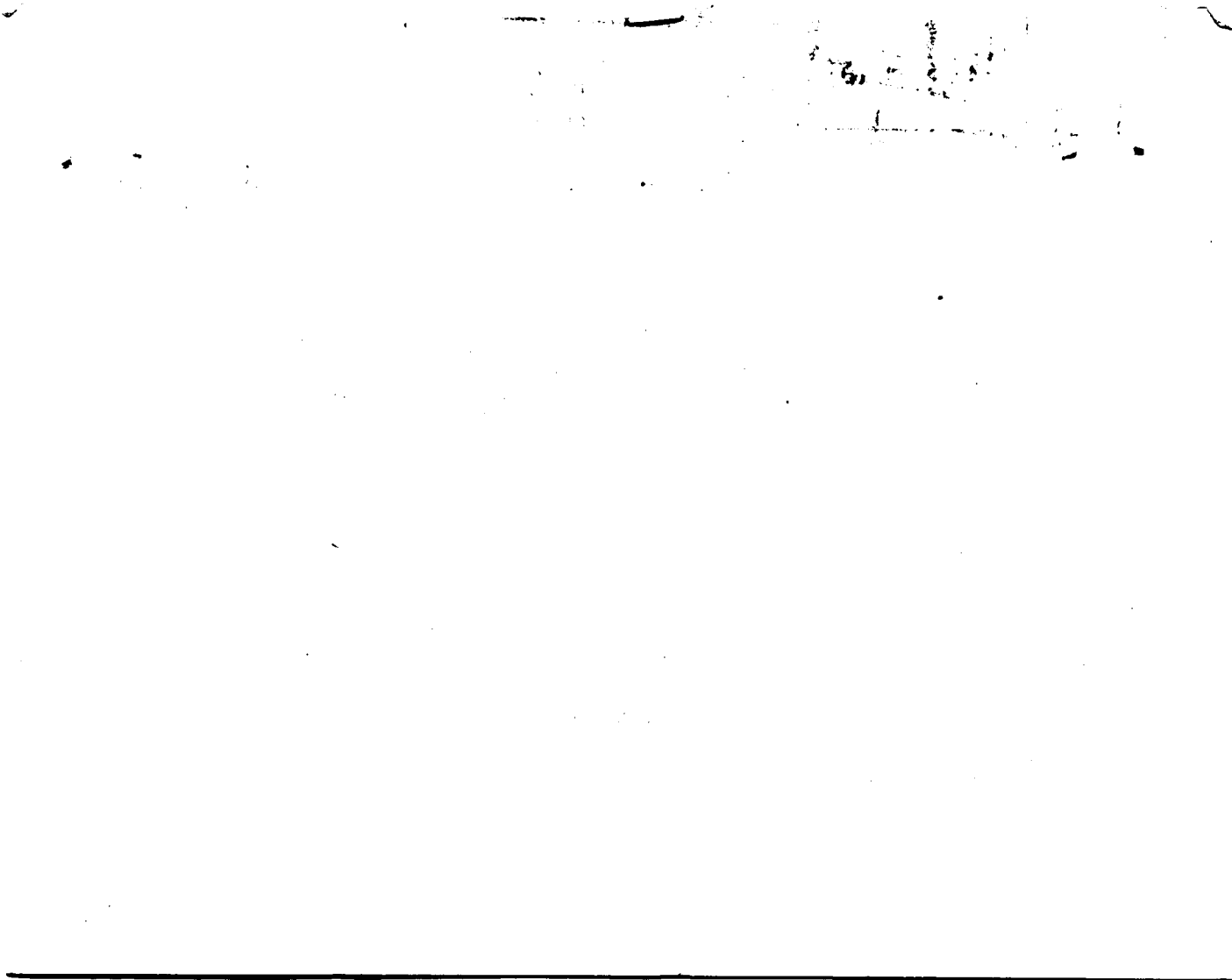
(Signature) Chas. F. Hammer
Physician
(Physician or midwife)

Given names added from a supplemental report.

19

Address Salmon
Filed 3/10 1923 Maieing Greene
Registrar

Registrar



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-2-11		RECEIVED APR 21 1923 BUREAU OF VITAL STATISTICS		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH		Registration District No. 41		File No. 41722		Registered No.	
County of Paul		Registration District No. 246		St.		If death occurred in a hospital, institution or camp give its NAME instead of street and number.	
City of Salmon (No. , St.)							
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME					
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3. SEX m		4. COLOR OR RACE w.		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)		16. DATE OF DEATH Feb. 14 1923 (Month) (Day) (Year)	
6. DATE OF BIRTH Feb. 14 1923 (Month) (Day) (Year)		7. AGE Stillborn yrs. mos. ds.		IF LESS than 1 day how many hrs. or min?		17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h alive on 191 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: Stillborn	
8. OCCUPATION (a) Trade, profession or particular kind of work. (b) General nature of industry business or establishment in which employed (or employer)		9. BIRTHPLACE (State or Country) Salmon Idaho.		10. NAME OF FATHER Do not know		11. BIRTHPLACE OF FATHER (State or Country)	
12. MAIDEN NAME OF MOTHER Olive Esther Bohannon		13. BIRTHPLACE OF MOTHER Idaho Pauli		14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) O. C. G. Bohannon (Address) Salmon Ida.		15. Filed 4/10 1923 M. N. Greene Local Registrar	
16. DATE OF DEATH		17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h alive on 191 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: Stillborn		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.		19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 3-18-1923	
20. UNDERTAKER		ADDRESS		21. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL		22. UNDERTAKER ADDRESS	
23. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL		24. UNDERTAKER ADDRESS		25. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL		26. UNDERTAKER ADDRESS	

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

993-204033-412
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison **RECEIVED**

City of Rexburg **MAR 8 1923**

No. 100 **BUREAU OF VITAL STATISTICS**

CERTIFICATE OF BIRTH

File No. 110145

Hospital Primary Registration District No. 2118 Registered No. 873

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u> } and } Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Feb. 4th 1923</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth 8th Number of child of this mother now living, including present birth 5

FATHER FULL NAME <u>Thomas E. Ricks</u>	MOTHER FULL MAIDEN NAME <u>Maud E. DaBell</u>
RESIDENCE <u>Rexburg Idaho</u>	RESIDENCE <u>Rexburg Idaho</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>40</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Logan Utah</u>	BIRTHPLACE <u>Ogden Utah</u>
OCCUPATION <u> </u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born Dead Feb. 4th 1923 9-30 P. M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Parley Nelson

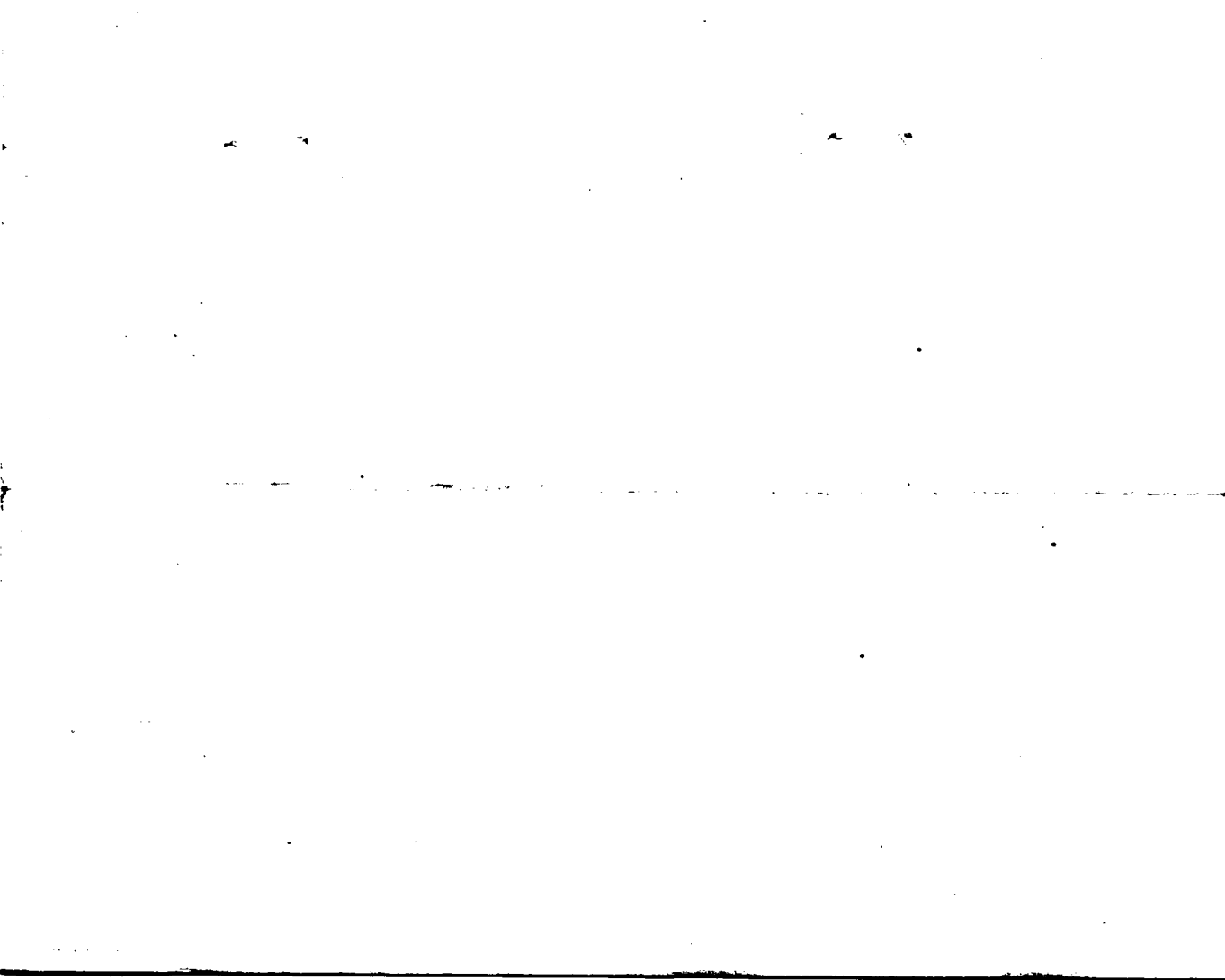
M. D.
(Physician or stillbirth)

Give names added from a supplemental report.

Address Rexburg Idaho

Filed 3/1 1923 Registrar.

Registrar.



1. PLACE OF DEATH

County of MadisonCity of Rexburg

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 100Registration District No. 2178

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 41479Registered No. 817

If death occurred in hospital, institution or sanatorium, give its NAME instead of street and number.

RECEIVED
MAR 8 - 1923
BUREAU OF VITAL
STATISTICS2. FULL NAME Baby Ricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDChild
(Write the word.)

6. DATE OF BIRTH

February4th1923

(Month)

(Day)

(Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.None(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country) Rexburg10. NAME OF
FATHERJ. B. Ricks Jr.11. BIRTHPLACE
OF FATHER(State or Country) Utah12. MAIDEN NAME
OF MOTHERMaud Deball13. BIRTHPLACE
OF MOTHER(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 3/11923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb423

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 41923

to

Feb 41923that I last saw him alive on 19and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Still Born. (No
anatomic fluids)

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Parley Nelson M. D.2-4-1923(Address) Rexburg, Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death yr. mos. days In the State yr. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Rexburg, Ida.

DATE OF BURIAL

2/5 1923

20. UNDERTAKER

David Young

ADDRESS

Rexburg, Ida.

189-6

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

231-227 033-235
PLACE OF BIRTH

STATE OF IDAHO

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison

City of Rexburg

No. _____ St. _____

MAR 8 1923

BUREAU OF VITAL

STATISTICS No. 100

CERTIFICATE OF BIRTH

File No. 110156

Hospital _____

Primary Registration District No. 2178

Registered No. 378

FULL NAME OF CHILD

Jarrah Blaser

(Certificate of no value without full name of child.)

Sex of Child Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of birth Feb 27 1923
(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER
FULL NAME Robert Blaser

RESIDENCE Plano

COLOR white AGE AT LAST BIRTHDAY 22 (Years)

BIRTHPLACE Rexburg

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Mary Street

RESIDENCE Plano

COLOR white AGE AT LAST BIRTHDAY 22 (Years)

BIRTHPLACE Plano

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 2:00 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. B. Rigby M.D.

(physician or midwife)

Give names added from a supplemental report.

Address Rexburg

Filed 3/1 1923 J. H. Young Registrar.

Registrar.

1945-1946

1947-1948

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 4/17 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Plano
(ST. _____
(COUNTY Madison
FATHER Robert

FILE NO. 110156
DATE OF BIRTH Feb 27
SEX OF CHILD Female
MOTHER Mary A. Blaser
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Sarah Blaser

Mary A. Blaser

Signature of Father or Mother.

1610

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of MadisonCity of ArcherNo. 436-716 033 318 St.

RECEIVED

APR 9 1925

BUREAU OF VITAL STATISTICS

Registration District No. 100

CERTIFICATE OF BIRTH

State File No. 110184

Hospital.....

Primary Registration District No. 2128 Local Registrar's No. 399

FULL NAME OF CHILD.....

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>3-16</u> , 192 <u>5</u> (Month) (Day) (Year)
--------------------------	---	-----	---	------------------------	--

What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 9Number of child of this mother now living, including present birth 6FULL NAME FATHER
Franklin Richard McFateFULL MAIDEN NAME MOTHER
Sarah E TaylorRESIDENCE ArcherRESIDENCE ArcherCOLOR White AGE AT LAST BIRTHDAY 40
(Years)COLOR White AGE AT LAST BIRTHDAY 32
(Years)BIRTHPLACE UtahBIRTHPLACE IdahoOCCUPATION FarmerOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:50 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Louise S. Rich

(Physician or midwife)

Give names added from a supplemental report.

Address Reeburg IdaFiled 4/6 1925

Registrar.

Registrar.

RECEIVED
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 STATE OF ILLINOIS
 CHICAGO, ILL. 6/1/1914

PLACE OF BIRTH

STATE OF ILLINOIS

DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

APR 9

Registration District No. _____ State File No. _____

Primary Registration District No. _____ Local Registrar No. _____

FULL NAME OF CHILD

(Certificate of no living without full name of child)

Child	Sex of	Weight or weight of child	Age in years or date of birth	Length in inches	Date of birth (Month) (Day)
-------	--------	---------------------------------	--	------------------------	--------------------------------------

When bacteriological section was used in event

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FATHER	MOTHER
NAME	NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

(Signature) _____
 (Physician or midwife)
 Address _____
 Filed _____
 Registered _____

When there was no attending physician or midwife, then the father, mother, etc., should make this return. A midwife child is one that neither parent nor shows other evidence of his or her birth.

Give names added from a supplemental report.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		S	
County of <u>Nez Perce</u>		RECEIVED MAR 14 1923 BUREAU OF VITAL STATISTICS	
City of <u>Webb</u>		CERTIFICATE OF BIRTH	
No. <u>794 107 035 168</u> St.		Registration District No. <u>97</u>	File No. <u>110222</u>
Hospital _____		Primary Registration District No. <u>2174</u>	Registered No. <u>5</u>
FULL NAME OF CHILD <u>Ralph Matson Gruell</u>		(Certificate of no value without full name of child.)	
Sex of Child <u>male</u>	Twin Triplet or other? <u>—</u> } and { Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>2/2</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			
What bacteriocidal solution was used in eyes? <u>Erythrol</u>			
Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FULL NAME <u>Walter Gruell</u>	FATHER		
RESIDENCE <u>Webb, Ida.</u>	MOTHER		
COLOR <u>White</u>	FULL MAIDEN NAME <u>Hazel Johnson</u>		
BIRTHPLACE <u>Mo.</u>	RESIDENCE <u>Webb</u>		
OCCUPATION <u>farmer</u>	COLOR <u>w</u> — AGE AT LAST BIRTHDAY <u>26</u> (Years)		
BIRTHPLACE <u>Webb</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>		OCCUPATION <u>Housewife</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
I hereby certify that I attended the birth of this child, who was <u>still born</u> at <u>11 p. M.</u> on the date above stated. (Born alive or stillborn)			
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.		(Signature) <u>William H. Stahl</u>	
Give names added from a supplemental report.		(Physician or midwife)	
_____, 19____		Address <u>Lapwai, Idaho</u>	
_____, 19____		Filed <u>3/1</u> 192 <u>3</u>	
Registrar.		Registrar.	



FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *My Peru*

City of *Arden*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ralph Matson Gruell

Registration District No.

Registration District No.

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *41511*

Registered No. *4*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Still Born.

(Month)

(Day)

1

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Walker Gruell

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Hazel Johnston

13. BIRTHPLACE OF MOTHER

(State or Country)

Kans Nebraska.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Walter Gruell

Arden Ida.

15.

Filed

3/1/23

19

W. B. Wain

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.

7

23

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him alive on

2/7/23

19.....

and that death occurred on the date stated above, at *11 P.* M.

The CAUSE OF DEATH* was as follows:

Still Birth.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. B. Wain

M. D.

2/7 1923

(Address) *Lapwai Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lapwai - Ida.

2/8 1923

20. UNDERTAKER

ADDRESS

L. B. Wain - Lapwai

Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

265-213 035-315
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of May Pine
City of Juniper
No. St.
Hospital White
Primary Registration District No. 1009
Registration District No. 96
File No. 110231
Registered No. -16
FULL NAME OF CHILD Baby Bowles

(Certificate of no value without full name of child.)

Sex of Child female Twin Triplet or other? — and — Number in order of birth — Legitimate? yes Date of birth 2/13 1923
(Month) (Day) (Year)
(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? Alconol.

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Therman Bowles</u>	FULL MAIDEN NAME	<u>Mildred Langston</u>
RESIDENCE	<u>Juniper Idaho</u>	RESIDENCE	<u>Juniper Idaho</u>
COLOR	<u>white</u>	COLOR	<u>W.</u>
AGE AT LAST BIRTHDAY	<u>25</u> (Years)	AGE AT LAST BIRTHDAY	<u>24</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Texas</u>
OCCUPATION	<u>farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Full Term at 3 30 p. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. J. Gu. L. White

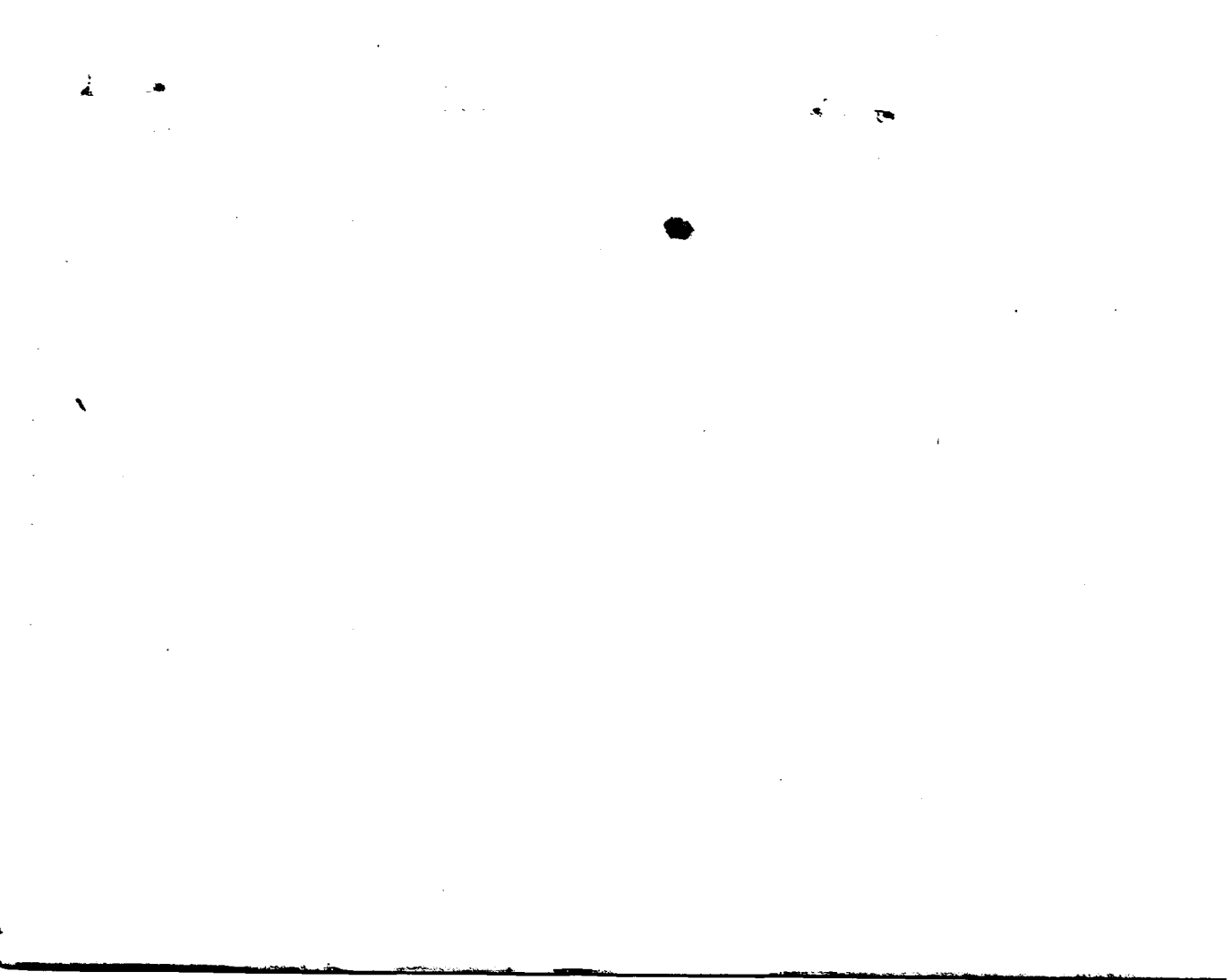
(Physician or midwife)

Give names added from a supplemental report.

Address Juniper Idaho

Filed 3/1/23 1923 Registrar William H. Hall

Registrar.



CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nez PerceCity of Levinston

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

STATISTICS

2. FULL NAME

Baby BowlesState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

2 13 923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Infant Stillborn

9. BIRTHPLACE

(State or Country)

Levinston Ida

10. NAME OF FATHER

Therman Bowles

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Mildred Langston

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mildred Langston
City Levinston
Idaho
Local Registrar

15.

Filed

3 23 19

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 13 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 13 1923 at Levinston Ida
that I last saw him alive on Feb 13 1923
and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Still Born—premature
(3 1/2 months)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Edgar L. White M. D.Feb 14 1923 (Address) Levinston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Levinston Ida 2 14 1923

20. UNDERTAKER

ADDRESS

Passar and Co Levinston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

793-29 412 815
PLACE OF BIRTH

RECEIVED

APR 3 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twain Falls
City of Twain Falls

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. _____

Registration District No. 57

File No. 110395

Hospital County General

Primary Registration District No. 1085

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Mar 9</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 12 (11) Number of child of this mother now living, including present birth 9

FATHER
FULL NAME Henry Giles
RESIDENCE Kimberly Idaho
COLOR W AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Milton Utah
OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Hettie May Banks
RESIDENCE Kimberly Idaho
COLOR W AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Pleasant Creek Utah
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 9:20 AM M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Joseph H. Davis

(Physician ~~unavailable~~)

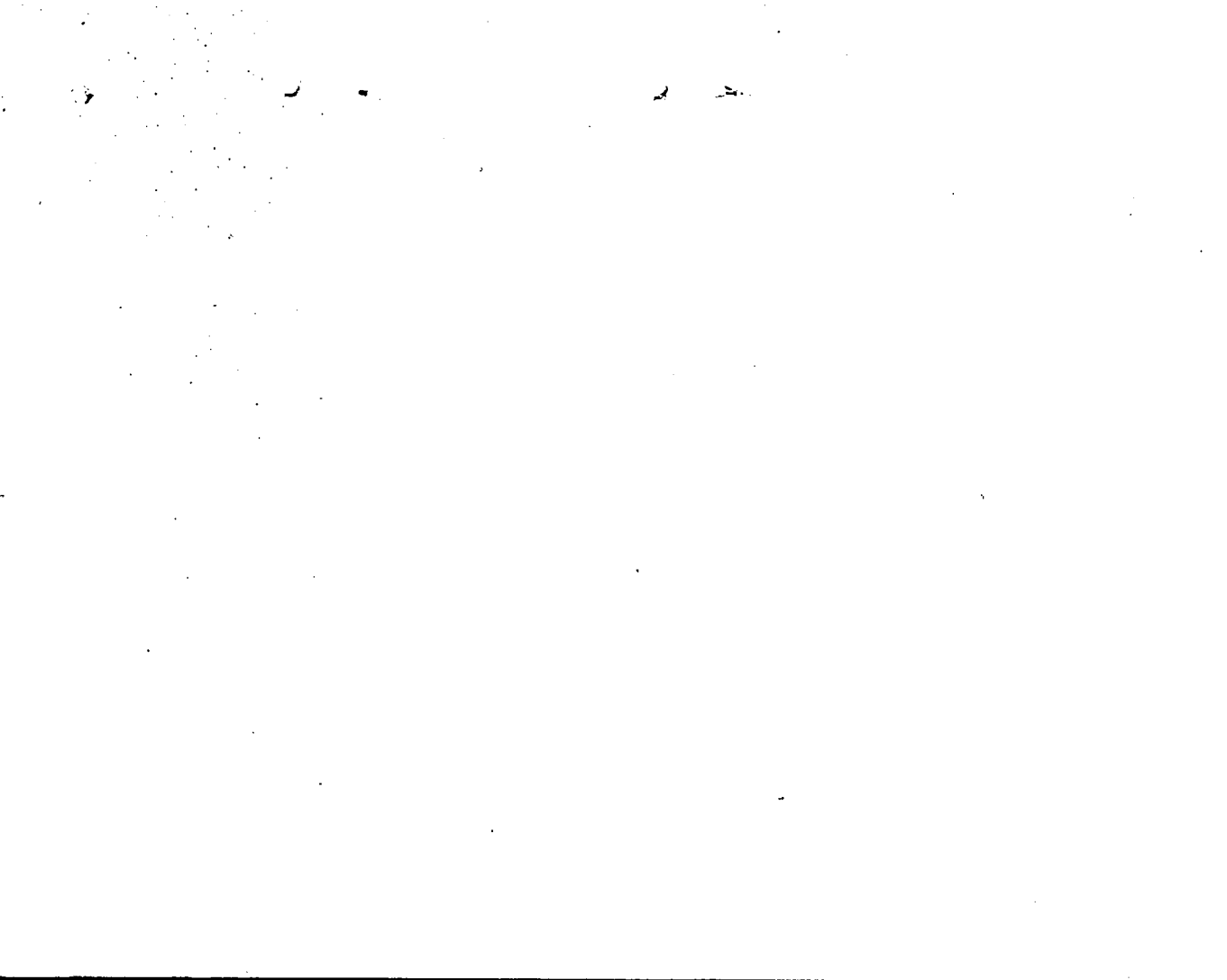
Give names added from a supplemental report.

Address Kimberly, Idaho

Filed April-1 1923

John S. Coughlin
Registrar.

Registrar.



1. PLACE OF DEATH

County of *Van Falls*
City of *Van Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Not named — Giles*RECEIVED CERTIFICATE OF DEATH
APR 21 1923
BUREAU OF VITAL STATISTICS
Registration District No. *36*
Primary Registration District No. _____
(St.) _____State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *41827*Registered No. *4*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Mar - 9 - 1923
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Van Falls Idaho*

10. NAME OF FATHER

Henry Giles

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

Nettie May Hawks

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Mar 10* 19 *23* *J. M. Davis*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 9 - 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Mar 9 - 1923* to *Mar 9 - 23*that I last saw him alive on *Mar 9 - 1923*and that death occurred on the date stated above, at *9:50 A.M.*

The CAUSE OF DEATH* was as follows:

Still birth at term.
~~*death from unknown cause*~~(Duration) Yrs. mos. *5* ds.Contributory *No cause ascertainable*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. M. Davis* M. D.*3/9/23* (Address) *Kimberly Id*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

on farm

DATE OF BURIAL

Mar 10 19 *23*

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

135-213-243-215
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Valley
City of Arliing
No. _____ St. _____

RECEIVED

CERTIFICATE OF BIRTH

110419

Registration District No. 15

File No. _____

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD

Stillbirth no name

(Certificate of no value without full name of child.)

Sex of Child girl

Twin
Triplet
or other?

- { and

Number
in order
of birth

-

Legiti-
mate?

yes

Date of
birth

Jan 13 1923
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 1

Number of child of this mother now living, including present birth... 0

FULL
NAME

FATHER

Jim Alexander

RESIDENCE

Arliing, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

2 6
(Years)

BIRTHPLACE

Bulgaria

OCCUPATION

humberman

FULL
MAIDEN
NAME

MOTHER

Mrs Ida Kantola Alexander

RESIDENCE

Arliing, Ida.

COLOR

white

AGE AT LAST
BIRTHDAY

23
(Years)

BIRTHPLACE

Finland

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... born dead... at... 12 (noon)... M.
on the date above stated.

(Born alive or stillborn)

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

Mildy Kantola
(no physician present)
(Physician or midwife)

Give names added from a supplemental report.

Address

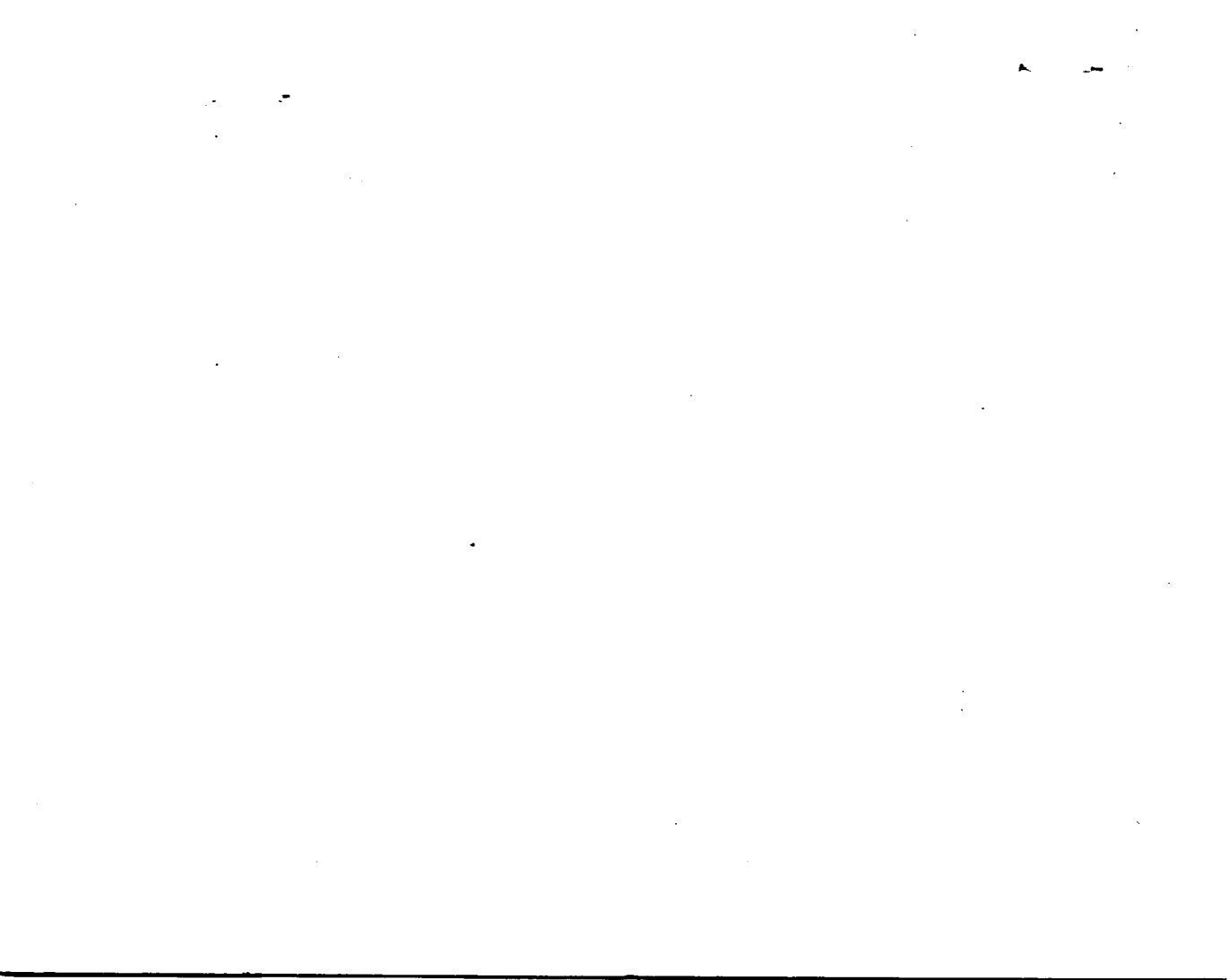
Arliing, Idaho

Filed

1923

Gilla Carr
Duffy Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Valley
City of Arling

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

MARCH 14 1923

Registration District No. 15

BUREAU OF VITAL STATISTICS

Registration District No. 15 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 41560Registered No. 1896

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

stillbirth
(Write the word.)

6. DATE OF BIRTH

Jan 13 1923
(Month) (Day) (Year)

7. AGE

9 months (utero gestation)IF LESS than 1 day
how many..... hrs.
or..... min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Arling Idaho

10. NAME OF FATHER

Jim Alexander

11. BIRTHPLACE OF FATHER

(State or Country)

Bulgaria

12. MAIDEN NAME OF MOTHER

Ida Kantola Alexander

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Matilda Kantola

(Address)

Arling Idaho

15.

Filed

19

Stella Cairn

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Unknown

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

stillbirth cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) (no physician present) M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.....

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
753 223 685 753
County of Bannock

City of Pocatello

No. St.

Hospital.....

FULL NAME OF CHILD Still born

(Certificate of no value without full name of child.)

Sex of Child	<u>Female</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	<u>unknown</u>	Date of birth	<u>3</u>	<u>-</u>	<u>23</u>	<u>1923</u>
							(Month)	(Day)	(Year)		

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>unknown</u>	FULL MAIDEN NAME	<u>Mrs L. Peterson</u>
RESIDENCE	<u>✓</u>	RESIDENCE	
COLOR	<u>✓</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>✓</u> (Years)	AGE AT LAST BIRTHDAY	<u>32</u> (Years)
BIRTHPLACE	<u>✓</u>	BIRTHPLACE	<u>unknown</u>
OCCUPATION	<u>✓</u>	OCCUPATION	<u>✓</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 A. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. J. Howard M.D.
Physician
(Physician or midwife)

Address Pocatello, Idaho.
Filed 4/2 192 3
Registrar H. Young

Registrar.

(OVER)

Registrar.

RECEIVED
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
APR 21 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH
110532
Registration District No. 28 State File No. 87
Primary Registration District No. 2164 Local Registrar's No. 4876

S

Mother sick with influenza enroute Salt Lake City
to Seattle. Premature labor 8 mos. Mother died
pulmonary aedema.

2

BIRTH

APR 21 1923

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

S

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

110575

City of Bloomington Registration District No. 52 State File No. 2136
 No. 653-213004/617 St. 617 Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twins Triplet or other? <u> </u>	and { Number in order of birth <u> </u> }	Legitimate? <u>Yes</u>	Date of birth <u>3-13-1923</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth Number of child of this mother now living, including present birth

FATHER		MOTHER	
FULL NAME <u>Alvin Becker</u>	FULL MAIDEN NAME <u>Emma E. Ward</u>	FULL NAME <u>Alvin Becker</u>	FULL MAIDEN NAME <u>Emma E. Ward</u>
RESIDENCE <u>Bloomington</u>	RESIDENCE <u>Bloomington</u>	RESIDENCE <u>Bloomington</u>	RESIDENCE <u>Bloomington</u>
COLOR <u>W</u>	COLOR <u>W</u>	COLOR <u>W</u>	COLOR <u>W</u>
AGE AT LAST BIRTHDAY <u>48</u> (Years)	AGE AT LAST BIRTHDAY <u>46</u> (Years)	AGE AT LAST BIRTHDAY <u>48</u> (Years)	AGE AT LAST BIRTHDAY <u>46</u> (Years)
BIRTHPLACE <u>Bloomington</u>	BIRTHPLACE <u>Bloomington</u>	BIRTHPLACE <u>Bloomington</u>	BIRTHPLACE <u>Bloomington</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Farmer</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

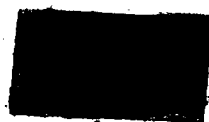
(Signature) Dr. J. H. Kelley

Address Montpelier, Ida

Filed 9-13-23 192

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

553-216 007-493
PLACE OF BIRTH

MAY 7 1923

BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine

City of Hailey

No. 2 St.

Hospital

CERTIFICATE OF BIRTH

110661

Registration District No. 57

File No.

Primary Registration District No. 2022

Registered No. 18

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>4-16</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	----------------------------------	-----	------------------------------------	------------------------	--

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FULL NAME FATHER Alford John Nelson

FULL MAIDEN NAME MOTHER Alice N. Mills

RESIDENCE Hailey, Ida

RESIDENCE Hailey, Ida

COLOR white AGE AT LAST BIRTHDAY 48 (Years)

COLOR white AGE AT LAST BIRTHDAY 32 (Years)

BIRTHPLACE Sweden

BIRTHPLACE Idaho

OCCUPATION Miner

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Robert H. Wright, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

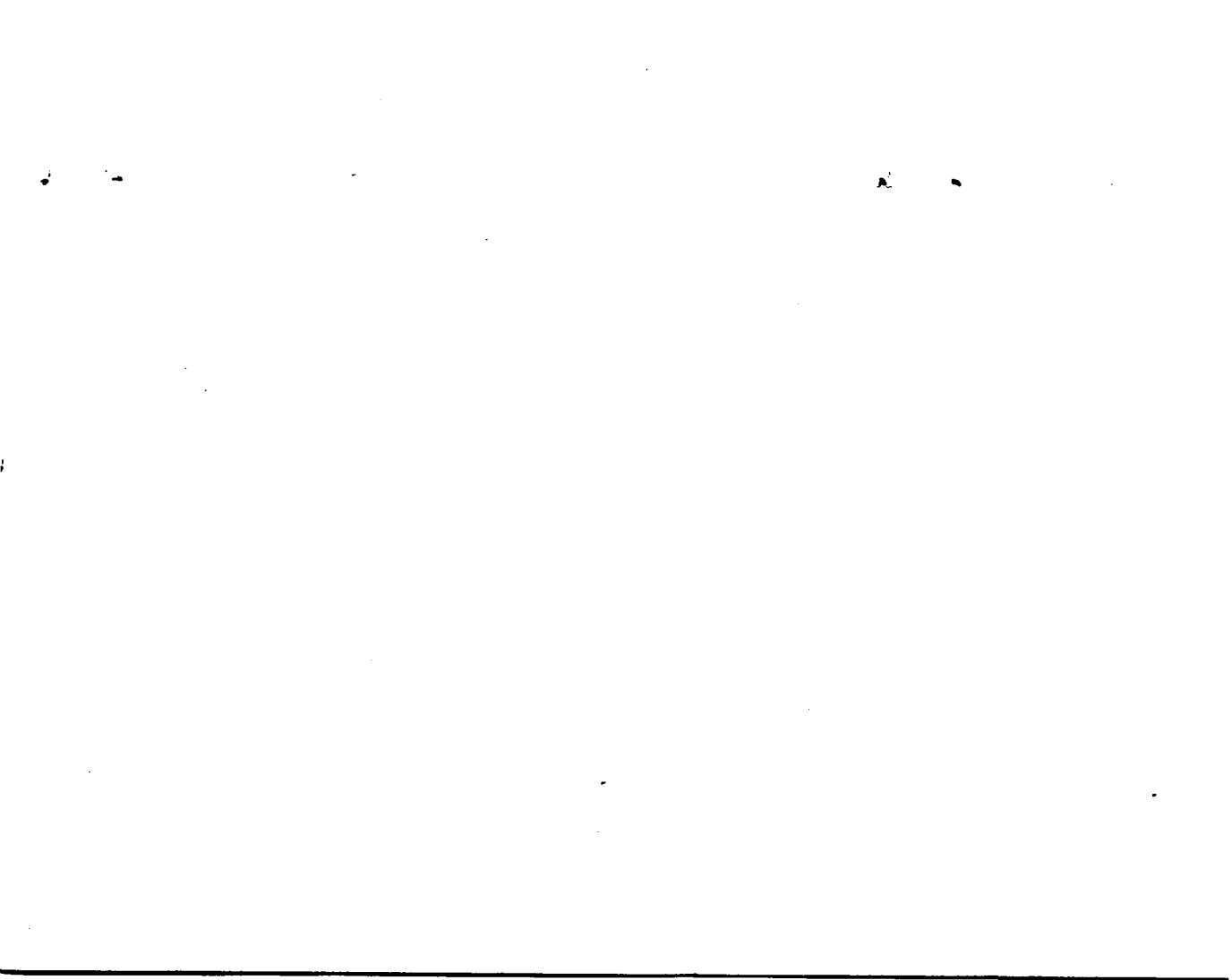
Hailey, Ida

Filed

5-1 1923

Robert H. Wright
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *Blaine*
City of *Hailey*RECEIVED
MAY 7 1923Registration District No. *2022*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Nelson*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *41649*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH.

April 16 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*

9. BIRTHPLACE

(State or Country)

Hailey, Ida.

10. NAME OF FATHER

J. A. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Alice Mills

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. A. Nelson*

(Address)

Hailey, Ida.

15.

Filed

5-1

1923

N. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 16 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Robert H. Wright* M. D.4/17/23 (Address) *Hailey, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey Ida. *April 17 1923*

20. UNDERTAKER

ADDRESS

W. H. Harris *Hailey*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH **533-125009 259**
Bonner
County of _____
City of **Edgemere**
No. _____ St. _____
Hospital _____
Registration District No. **85**
Primary Registration District No. **2185**
File No. _____
Registered No. **257**
BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
110677 S
RECEIVED
MAY 7 1923

FULL NAME OF CHILD **Clifford Ellis**
(Certificate of no value without full name of child.)
Sex of Child **M**
Twin Triplet or other? _____ } and { Number in order of birth _____
Legitimate? **Yes**
Date of birth **April 25 1923**
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? **none**
Number of child of this mother, including present birth **8**
Number of child of this mother now living, including present birth **7**

FATHER		MOTHER	
FULL NAME	Frank Ellis	FULL MAIDEN NAME	Sophie Keremer
RESIDENCE	Edgemere, Idaho	RESIDENCE	Edgemere, Idaho
COLOR	W.	COLOR	W.
AGE AT LAST BIRTHDAY	35 (Years)	AGE AT LAST BIRTHDAY	38 (Years)
BIRTHPLACE	Neb.	BIRTHPLACE	Germany
OCCUPATION	Farmer	OCCUPATION	Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

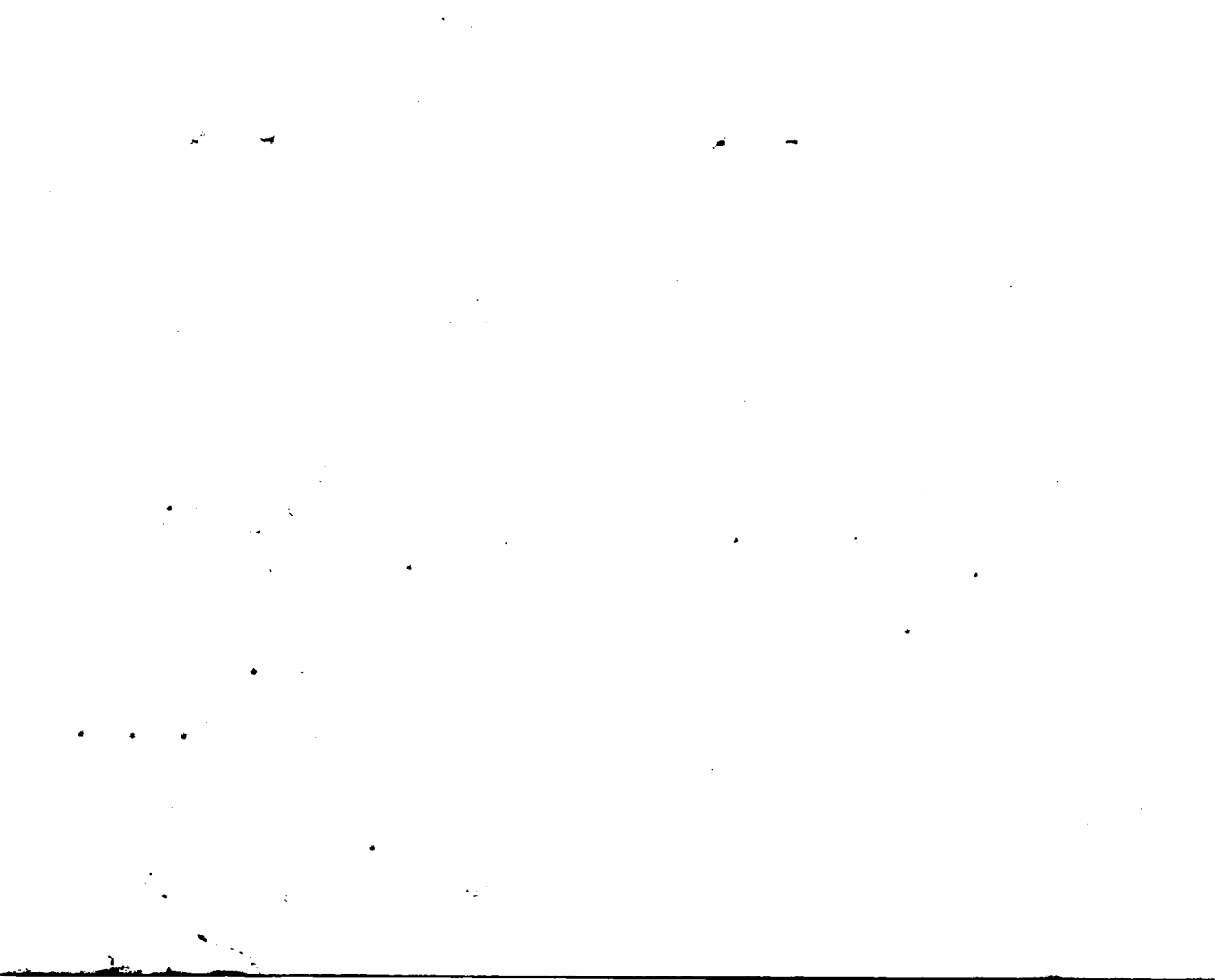
I hereby certify that I attended the birth of this child, who was **Still Born** at **7.45. A.** M. on the date above stated.
(Born alive or stillborn)

{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

Give names added from a supplemental report.
_____, 19____
_____, 19____

(Signature) _____
Phys. _____ (Physician or midwife)

Address **Priest River, Idaho**
Filed **May 11 1923**
Registrar. _____



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BonnerCity of Edgemere

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clifford Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

April 25 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Ellis

11. BIRTHPLACE OF FATHER

(State or Country)

Neb.

12. MAIDEN NAME OF MOTHER

Sophie Keremer

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William J. Erickson

15.

Filed May 1 1923

Local Registrar

RECEIVED CERTIFICATE OF DEATH

MAY 7 1923

Registration District No. 85County Registration District No. 2185

BUREAU OF STATISTICS

41660

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 3Registered No. 90

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 25 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on not 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth.Premature at 6 Mo.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Apr 25, 1923(Address) Priest River, Ida,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Edgemere Idaho

DATE OF BURIAL

April 26, 1923

20. UNDERTAKER

Frank Ellis

ADDRESS

Edgemere Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

295-216012-255

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

BUREAU OF VITAL STATISTICS

County of Butte

CERTIFICATE OF BIRTH

City of Moore

BUREAU OF VITAL STATISTICS

File No. 110679

No. _____ St. _____

Primary Registration District No. _____ Registered No. _____

Hospital _____

FULL NAME OF CHILD Bulah KingSex of Child MTwin
Triplet
or other?
(To be answered only in event of plural births)and
Number
in order
of birth

Legitimate?

Date of Birth 4-16-23

(Month) (Day) (Year)

FATHER
Name Mark H. King
RESIDENCE MooreMOTHER
Name Bulah Bever
RESIDENCE MooreCOLOR W AGE AT LAST BIRTHDAY 25 (Years)COLOR W AGE AT LAST BIRTHDAY 23 (Years)BIRTHPLACE UtahBIRTHPLACE IdahoOCCUPATION FarmerOCCUPATION Same

Number of child of this mother, including present birth. _____ Number of children of this mother now living, including present birth. _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 7309, M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. M. Cannon

(Physician or midwife)

Given names added from a supplemental report.

Address Arco, Ida
Filed 4/15/23 M. Cannon
Registrar

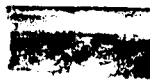
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



STATE

REPORT

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 5/8 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth	(CITY	<u>Moore</u>	FILE NO.	<u>110679</u>
	(ST.	<u>Idaho</u>	DATE OF BIRTH	<u>April 16, 1923</u>
	(COUNTY	<u>Butte</u>	SEX OF CHILD	<u>Female</u>
FATHER		<u>Mark K. King</u>	MOTHER	<u>Berulah M. Beyer</u> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

(The child died during birth) Berulah

Mark K. King
Signature of Father or Mother.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

366-113-014-385
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon

APR 21 1923

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

City of _____

No. _____

St. _____

Registration District No. 3

File No. 110711

Hospital _____

Primary Registration District No. 2005

Registered No. 46

FULL NAME OF CHILD Alfred Conn

(Certificate of no value without full name of child.)

Sex of Child M

Twin
Triplet
or other?

{ and { Number
in order
of birth

Legitimate?
Yes

Date of birth Mar 13 1923

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth.....

Number of children of this mother now living, including present birth.....

FULL NAME

FATHER

FULL MAIDEN NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

(Years)

COLOR

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was.....
on the date above stated.

Stillborn M.

(Born alive or stillborn)

(Signature)

Geo. Hall

(Physician or midwife)

Give names added from a supplemental report.

Address

Star, Idaho

Filed

Mar. 14 - 1923

Registrar.

Registrar.

STATE OF NEW YORK
 DEPARTMENT OF SOCIAL WELFARE
 BUREAU OF VITAL RECORDS
CERTIFICATE OF BIRTH

Registration District No. _____
 This No. _____
 County No. _____
 Birth No. _____

DATE OF BIRTH _____
 PLACE OF BIRTH _____

SEX _____
 COLOR _____
 HEIGHT _____
 WEIGHT _____
 BUILD _____

DATE OF DEATH _____
 PLACE OF DEATH _____
 CAUSE OF DEATH _____

NAME OF MOTHER _____
 NAME OF FATHER _____

RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____

DATE OF BIRTH _____
 PLACE OF BIRTH _____
 CAUSE OF BIRTH _____

DATE OF DEATH _____
 PLACE OF DEATH _____
 CAUSE OF DEATH _____

DATE OF BIRTH _____
 PLACE OF BIRTH _____
 CAUSE OF BIRTH _____

DATE OF DEATH _____
 PLACE OF DEATH _____
 CAUSE OF DEATH _____

DATE OF BIRTH _____
 PLACE OF BIRTH _____
 CAUSE OF BIRTH _____

DATE OF DEATH _____
 PLACE OF DEATH _____
 CAUSE OF DEATH _____

RECEIVED CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Rapid Death Report No. 3

County of Canyon

BUREAU OF VITAL STATISTICS District No. 2005-

City of Hilder Middle

St.)

File No.

41688

Registered No.

24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alfred Conors

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 189-6

3. SEX

M

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Mar 12 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many.....hrs. or
.....Yrs.....Mos.....ds.min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Iron
Miller

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

William Connor

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Lucy Chisholm

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

W. E. Connor
Hilder Middle

15.

Filed

Mar. 14 - 1923

John H. Meyers
Local Registrar

16. DATE OF DEATH

Mar 12 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 192

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. E. Connor

19 (Address) Hilder Middle - Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Ida

3-14-1923

20. UNDERTAKER

ADDRESS

J. V. Beckham Caldwell

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

264-013-014-663
PLACE OF BIRTH

RECEIVED
APR 21 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon

City of Caldwell

No. 18" & Blaine St.

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

Registration District No.

3

File No.

110713

Hospital

Primary Registration District No.

1005

Registered No.

48

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child	-----	Twin Triplet or other?	{ and { Number in order of birth	Legiti- mate? Yes	Date of birth	3/13	1923
			(To be answered only in event of plural births)		(Month)	(Day)	(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth.....2..... Number of child of this mother now living, including present birth.....0.....

FATHER
FULL NAME Wilber E. Youmans
RESIDENCE 18" & Blaine Caldwell
COLOR White AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Canada
OCCUPATION Mechanic

MOTHER
FULL MAIDEN NAME Sarah Marie Wolfe
RESIDENCE 18" & Blaine St. Caldwell
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Nebraska
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was.....stillborn..... at.....10:30.....P.....M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

....., 19.....

Registrar.

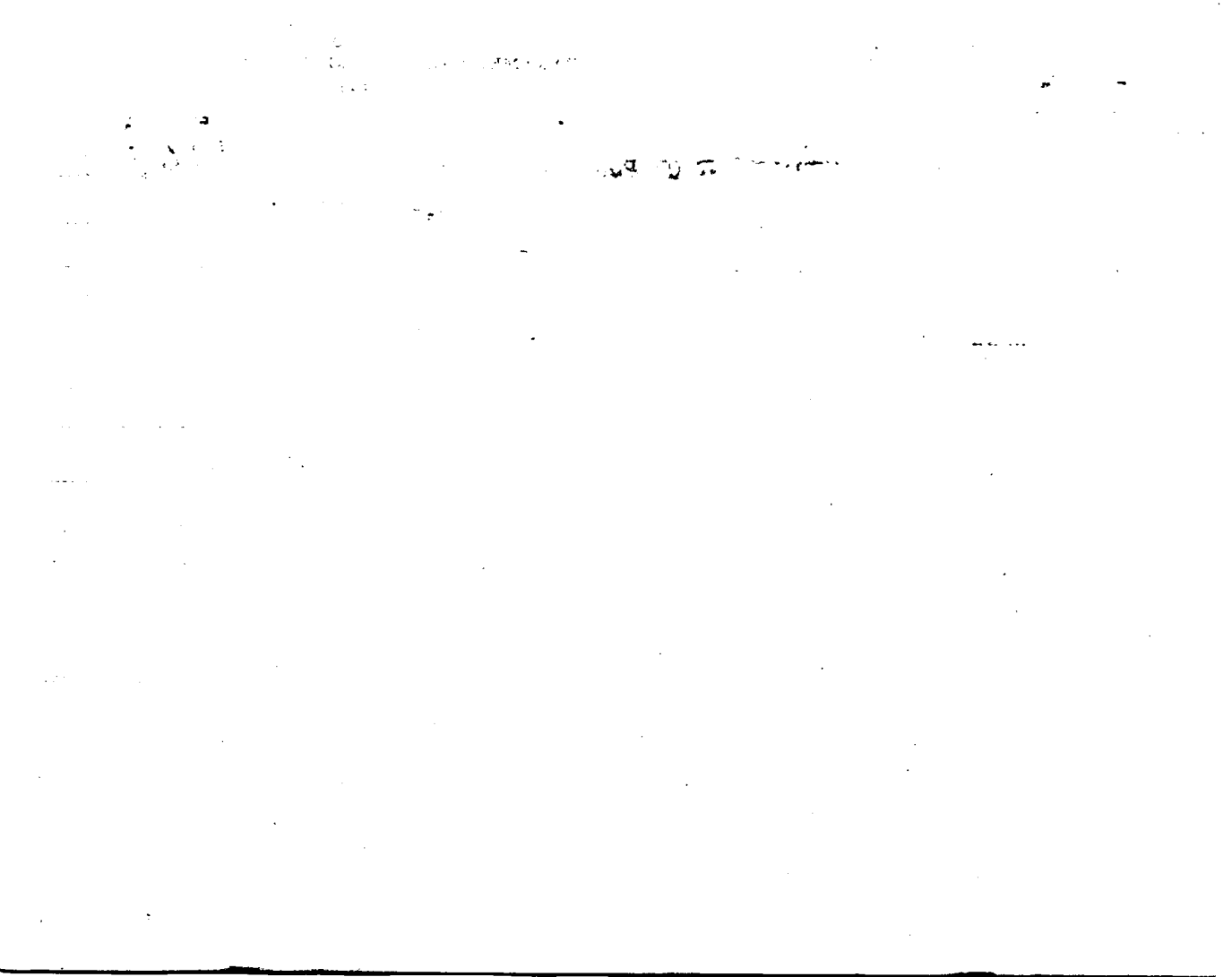
(Signature) C. M. Kaley
M. D.

(Physician or midwife)

Address Caldwell, Idaho

Filed Mar. 14 1923 John V. Mayer -

Registrar.



Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY _____ FILE NO. 110713
 (ST. _____ DATE OF BIRTH _____
 (COUNTY _____ SEX OF CHILD _____
 FATHER _____ MOTHER _____
 (Maiden Name)

RECEIVED

MAY 12 1923

SEAL OF VITAL
STATISTICS

I HEREBY CERTIFY that the child herein described has been named:

*We are very sorry that the Doctor failed to inform
 that our baby was born dead. So we did not name.*

Signature of Father or Mother

Mrs. Wilber E. Youmans

from you

lit.

37.

RECEIVED

APR 21 1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Canyon*City of *Caldwell*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Billy Younman*Registration District No. *3*Primary Registration District No. *2005*Statistics (No. *26*)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *41687*Registered No. *26*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*M**white*

(Write the word.)

6. DATE OF BIRTH

3
(Month)*13*
(Day)*1923*
(Year)

7. AGE

Yrs. Mos. da.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. E. Younman

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Sarah M. Wolf

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. E. Younman
W. E. Younman

15.

Filed *Mar. 14 - 1923**John H. Meyer*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

3-13-23

17. I HEREBY CERTIFY, That I attended deceased from

Mar 13 1923 to *Mar 13 1923*
that I last saw him alive on *Mar 13 1923*and that death occurred on the date stated above, at *11 P.* M.

The CAUSE OF DEATH* was as follows:

Stillborn
Me. Rubrum
monilia
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Address)

W. E. Younman
577 1923
Spencer St

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Caldwell**3-14-1923*

20. UNDERTAKER

ADDRESS

*E. V. Beckman**Caldwell*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

665-20903-133

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bern

City of Emmett

No. _____ St. _____

Hospital _____

RECEIVED

CERTIFICATE OF BIRTH

MAY 4 1923

BUREAU OF VITAL

Registration District No. _____

File No. 110805

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u>	and	Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>4-9-1923</u> (Month) (Day) (Year)
----------------------------	---------------------------------	-----	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FULL NAME <u>FATHER</u> <u>Hugh Owen</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Dora V. Allen</u>
RESIDENCE <u>Emmett</u>	RESIDENCE <u>Emmett</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Ind.</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 4 9 M.
on the date above stated. (Born alive or stillborn)

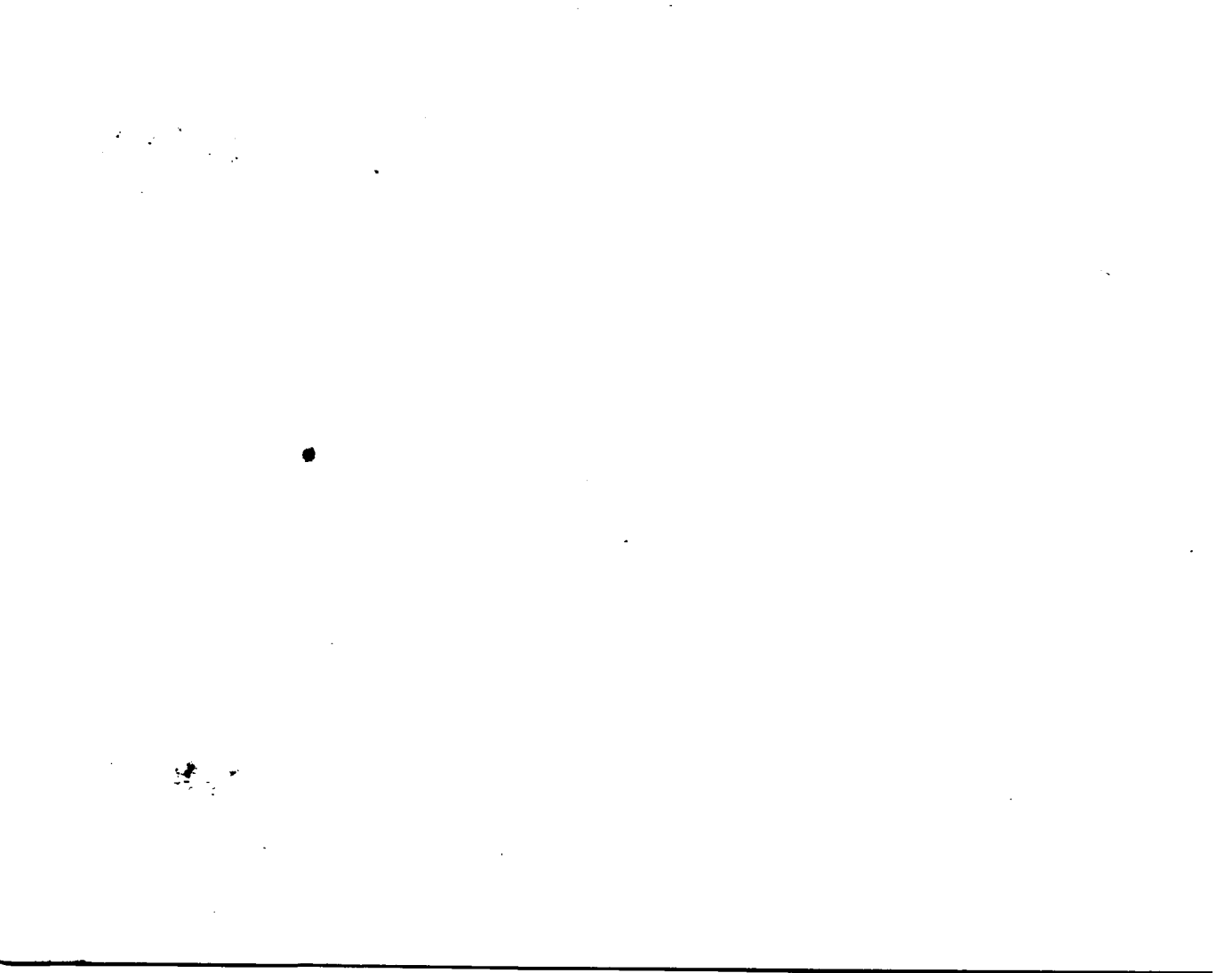
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Burt O. Clark
Emmett, Id.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address _____
Filed 5/3 1923 J. H. Reynolds
Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

445-217076-876
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jefferson
City of Lewesville
No. _____ St. _____
Hospital _____
Primary Registration District No. 2176
File No. 110827
Registered No. 98
FULL NAME OF CHILD Dorothy May Duncan
(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? no and Number in order of birth 1 Legitimate? yes Date of birth Feb 17 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. 3 Number of child of this mother now living, including present birth. 3

FATHER
FULL NAME Thomas Duncan
RESIDENCE Lewesville
COLOR W AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Missouri
OCCUPATION Miner

MOTHER
FULL MAIDEN NAME Gladys J. J. J.
RESIDENCE Lewesville
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 6:30 A M.
on the date above stated. (Born alive or stillborn) Abolished

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. S. Moody
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____
_____, 19____
Registrar.

Address Marion
Filed 5-10 1923 Ray H. Fisher
Registrar.

this to by only lived
a few minutes and
enjoyed the
delicious

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Minidoka RECEIVED
City of Rupert APR 23 1923
No. 62-217034-613 St. Registration District No. 19 State File No. 110904
Hospital..... Primary Registration District No. 2015 Local Registrar's No. 35
FULL NAME OF CHILD (Unnamed) Roberts

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>3</u>	Legitimate? <u>yes</u>	Date of birth <u>Mar 12</u> , 19 <u>23</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 3

FATHER FULL NAME <u>Livingston H. Roberts</u> RESIDENCE <u>Minidoka, Idaho</u> COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>41</u> (Years) BIRTHPLACE <u>Oregon</u> OCCUPATION <u>R.R. Boiler Washer</u>	MOTHER FULL MAIDEN NAME <u>Ida May Wallace</u> RESIDENCE <u>Minidoka, Idaho</u> COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>38</u> (Years) BIRTHPLACE <u>Nebraska</u> OCCUPATION <u>Housewife</u>
---	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:16 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Leland Frasier
Physician
(Physician or midwife)

Address Rupert, Idaho
Filed Apr. 4 1923 E. E. Elmore

Registrar.

Registrar.

DO NOT WRITE IN THESE SPACES
 THIS CARD IS TO BE USED FOR THE PURPOSE OF RECORDING THE BIRTH OF A CHILD
 AND IS NOT TO BE USED FOR ANY OTHER PURPOSE
 IT IS THE DUTY OF THE BIRTH REGISTRAR TO SEE THAT THIS CARD IS
 FILLED IN ACCORDANCE WITH THE INSTRUCTIONS
 AND THAT THE INFORMATION IS CORRECT
 THE BIRTH REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CARD
 IF IT IS NOT FILLED IN ACCORDANCE WITH THE INSTRUCTIONS
 THE BIRTH REGISTRAR WILL NOT BE RESPONSIBLE FOR THE CONTENTS OF THIS CARD

PLACE OF BIRTH

COUNTY OF

CITY OF

NO. OF

HOSPITAL

FULL NAME OF CHILD

Sex of Child

(To be answered only in case of a child born
 or object of birth)

If last birth certificate submitted was used in case of

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL NAME

FATHER

FULL NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

COLOR

AGE AT LAST BIRTHDAY

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the _____ day of _____ at _____

{When there was no attending physician or midwife then the father, mother, or another make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.}

Give names signed from a supplemental report

(Signature)

(Physician or midwife)

Address

182

Model

Register

CERTIFICATE OF BIRTH

State, No. 20

Local Registrar's No.

110804

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

312-215 040-456
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of

Shoshone
Wallace

APR 21 1923

City of

BUREAU OF VITAL CERTIFICATE OF BIRTH

10996

No.

St.

REGISTRATION DISTRICT NO.

70

File No.

Hospital

Providence

Primary Registration District No.

1011

Registered No.

8

FULL NAME OF CHILD

Still Born

(Certificate of no value without full name of child.)

Sex of Child

M

Twin
Triplet
or other

One

and

(Number
in order
of birth

1st

Legiti-
mate?

yes

Date of
birth

Jan 15 1923

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

1

FULL
NAME

William F. Baker

FULL
MAIDEN
NAME

Catherine Dugue

RESIDENCE

Wallace, Ida

RESIDENCE

Wallace, Ida

COLOR

White

AGE AT LAST
BIRTHDAY

23

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

23

(Years)

BIRTHPLACE

Washington

BIRTHPLACE

Wisconsin

OCCUPATION

Mail Carrier

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was...
on the date above stated.

Stillborn 3:30 P.M.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

D. W. Hower
Physician or midwife

Give names added from a supplemental report.

Address

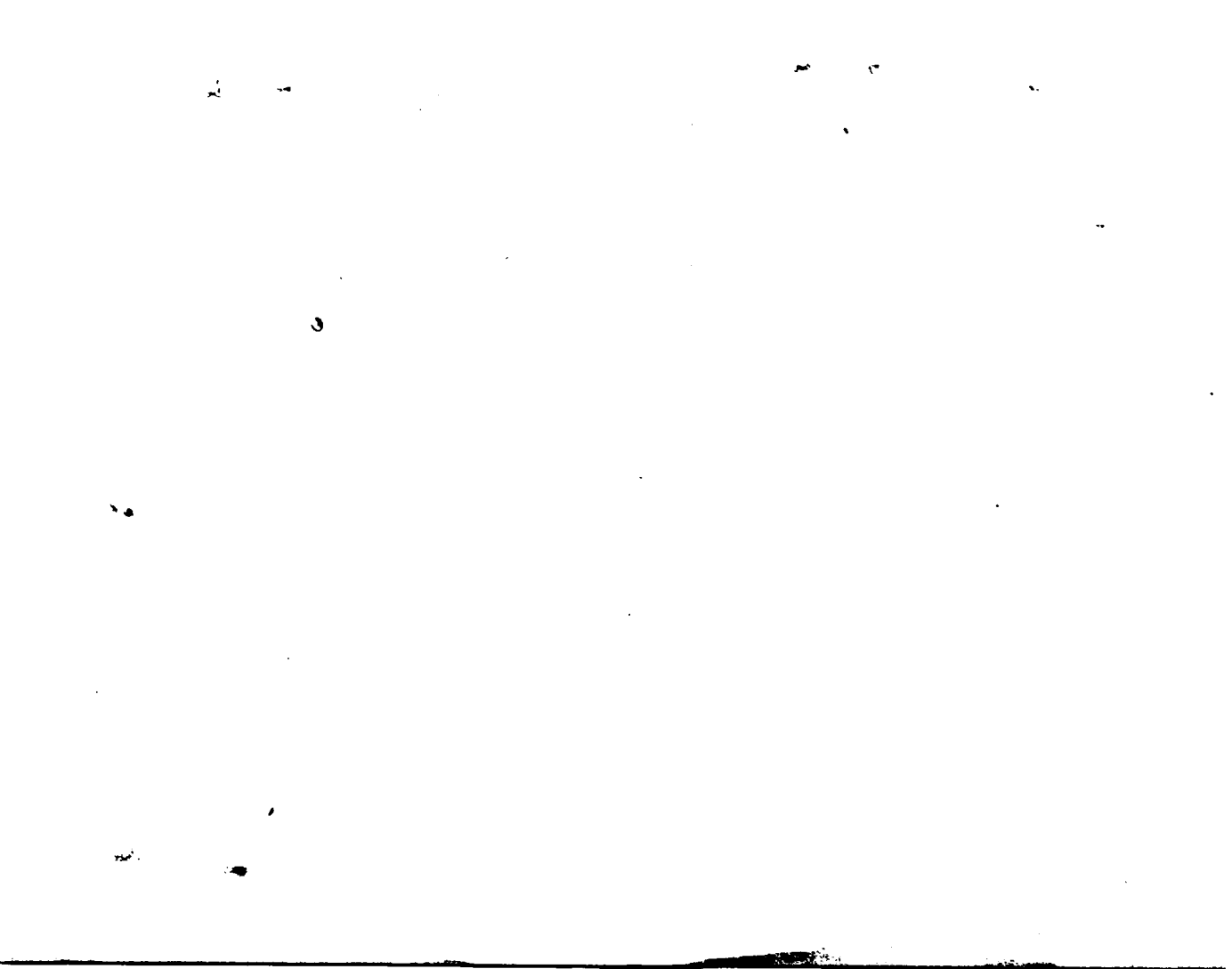
Wallace, Ida

Filed

Jan 20 1923 F. L. Jensen

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

41786

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw her alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed)

1/16 1923 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida 1-17-23

20. UNDERTAKER

ADDRESS

W. H. Haintell Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

893 204 042 731
PLACE OF BIRTH

RECEIVED

MAY 2 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

111047

County of Twin Falls
City of Twin Falls

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 37 File No. _____
Hospital _____ Primary Registration District No. 1085 Registered No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Hickling

Sex of Child <u>female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>4-4-1923</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2nd Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Lester Harold Hickling
RESIDENCE Twin Falls, Idaho
COLOR White AGE AT LAST BIRTHDAY 35
(Years)
BIRTHPLACE England
OCCUPATION Bank

MOTHER
FULL MAIDEN NAME Cathella May Graystein
RESIDENCE Twin Falls, Idaho
COLOR White AGE AT LAST BIRTHDAY 31
(Years)
BIRTHPLACE Washington
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 10 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 19____

Registrar.

(Signature) Dr. C. D. Weaver
Physician
(Physician or midwife)
Address Twin Falls, Idaho
John F. Loughlin
Filed May 1-23 1923
Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

MAY 2 1923

Registration District No. 37

County of *Lincoln*

Primary Registration District No. 1085

City of _____ (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Hinchling

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41812

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed May 1--23. 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

413-209-003-419

PLACE OF BIRTH

RECEIVED

MAY 12 1923

STATE OF IDAHO

Form 7-2, No. 11-C-10-8-7-11

County of

Bannock

BUREAU OF VITAL STATISTICS

Bureau of Vital Statistics

CERTIFICATE OF BIRTH

111161

City of

1 mile S.E. of Ft. Hall

Registration District No.

28

File No.

88

No.

St.

Hospital

Primary Registration District No.

2161

Registered No.

4903

FULL NAME OF CHILD

Haruko Matsumoto

Sex of

Child

Female

Twin,
Triplet
or other?

and

Number
in order
of birthLegiti-
mate?

yes

Date of

birth

April 9, 1923

(Month)

(Day)

(Year)

FULL
NAME

Rumabuke Matsumoto

FATHER

FULL
MAIDEN
NAME

Tsuehie Ujita

MOTHER

RESIDENCE

Ft. Hall Ind. Reservation

RESIDENCE

Ft. Hall Ind. Reservation

COLOR

Japanese

AGE AT LAST
BIRTHDAY

42

(Years)

COLOR

Japanese

AGE AT LAST
BIRTHDAY

38

(Years)

BIRTHPLACE

Japan

BIRTHPLACE

Japan

OCCUPATION

Farming

OCCUPATION

Housewife

Number of child of this mother, including present birth

5th

Number of children, of this mother, now living, including present birth

3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

born dead

(Born alive or stillborn)

at 8

P.

M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Harry R. Wheeler

Physician

(Physician or Midwife)

Given names added from a supplemental report

19

Address

Ft. Hall, Idaho

Filed

57, 1923

J. Young

Registrar

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

115- [REDACTED]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-1

RECEIVED

CERTIFICATE OF DEATH

41892

State of ~~Idaho~~BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH MAY 12 1923 Registration District No.

County of Bannock Primary Registration District No.City of 1 mile SE of Ft. Hall (No. 2161) near Hot Hall in CountyFile No. 58
Registered No. 4056

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

Haruko Matsumoto

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

April 9
(Month)

(Day)

1923
(Year)

7. AGE

still born0 yrs. 0 mos. 0 ds.IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ft. Hall Reservation

10. NAME OF FATHER

Runaake Matsumoto

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Kuchie Njita

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Matsumoto

(Address)

Ft. Hall

15.

Filed

4/91923R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 8
(Month)

(Day)

1923
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 7 1923 to April 9 1923that I last saw him alive on April 9 1923and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

apoplexy of placenta. Stillbirth at eight months.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Henry P. Wheeler M. D.April 9 1923 (Address) Ft. Hall Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem. Apr 10 1923

20. UNDERTAKER

ADDRESS

H. L. McHan Pocatello

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

216-112003-155
PLACE OF BIRTH

RECEIVED
MAY 12 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Boise
City of Central
No. _____ St. _____

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH 111166

Registration District No. 84 File No. _____
Hospital _____ Primary Registration District No. 2161 Registered No. _____

FULL NAME OF CHILD Baby Bauer
(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>4-12-1923</u> (Month) (Day) (Year)
-----------------------	------------------------------	-----------	--------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 5 Number of child of this mother now living, including present birth... 1

FULL NAME <u>Isaac Bauer</u>	FATHER	FULL MAIDEN NAME <u>Rita Jensen</u>	MOTHER
RESIDENCE <u>Central</u>		RESIDENCE <u>Central</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Whitney Ida</u>		BIRTHPLACE <u>Chesterfield Ida</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>W</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:45 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. B. Bach
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address _____
Filed 5-1 1923 W. B. Bach
Registrar.

2

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41878**

1. PLACE OF DEATH

County of **Blaine**City of **Central**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 14 1923
BUREAU OF
STATISTICS

Registration District No. **2161**Primary Registration District No. **84**

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Betty Barker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M**W**

(Write the word.)

6. DATE OF BIRTH

4 -
(Month)**12**
(Day)**1923**
(Year)

7. AGE

Yrs. Mos. da.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Central Ida

10. NAME OF FATHER

Wage Barker

11. BIRTHPLACE OF FATHER

(State or Country)

Whitney Ida

12. MAIDEN NAME OF MOTHER

Rita Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Chubbfield Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed **5 - 1****1923****Walter Bach**

Local Registrar

16. DATE OF DEATH

4 - 12
(Month)

(Day)

1923
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19.....

to

19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Still born (6 mo)

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Walter Bach

M. D.

..... 19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death

yrs.

mos.

In the
days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.....

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bear LakeCity of OvidNo. 753.118004.714 St.

RECEIVED
MAY 29 1923
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 57 State File No. 111181Hospital..... Primary Registration District No. 2136 Local Registrar's No.

FULL NAME OF CHILD.....

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and {	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>4 18 1923</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bacteriocidal solution was used in eyes?.....

Number of child of this mother, including present birth..... Number of child of this mother now living, including present birth.....

FULL NAME <u>Ivan Peterson</u>	FATHER	FULL MAIDEN NAME <u>Christina Paulson</u>	MOTHER
RESIDENCE <u>Ovid Idaho</u>		RESIDENCE <u>Ovid Idaho</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Ovid Idaho</u>		BIRTHPLACE <u>Liberty Ida</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>House-wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 6 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Geo F Ashley

Address.....

Filed.....

192.....

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

1. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 2. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 3. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 4. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 5. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 6. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 7. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 8. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 9. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 10. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 11. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 12. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 13. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 14. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 15. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 16. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 17. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 18. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 19. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 20. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 21. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 22. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 23. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 24. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 25. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 26. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 27. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 28. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 29. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 30. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 31. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 32. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 33. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 34. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 35. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 36. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 37. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 38. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 39. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 40. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 41. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 42. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 43. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 44. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 45. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 46. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 47. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 48. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 49. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 50. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 51. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 52. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 53. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 54. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 55. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 56. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 57. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 58. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 59. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 60. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 61. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 62. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 63. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 64. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 65. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 66. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 67. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 68. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 69. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 70. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 71. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 72. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 73. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 74. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 75. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 76. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 77. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 78. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 79. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 80. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 81. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 82. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 83. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 84. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 85. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 86. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 87. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 88. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 89. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 90. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 91. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 92. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 93. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 94. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 95. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 96. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 97. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 98. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 99. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE
 100. CHILDREN OF 14 YEARS OF AGE AND UNDER 18 YEARS OF AGE

PLACE OF BIRTH

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

111181

Hospital _____
 Primary Registration District No. _____
 Local Registrar's No. _____
 Registration District No. _____
 State File No. _____

FULL NAME OF CHILD

(To be answered only in event of birth) _____
 Sex of child _____
 Date of birth _____
 Month _____
 Year _____
 Legitimate _____
 Date of birth _____
 Month _____
 Year _____

What bacteriological examination was made in event

Number of child of the mother including present birth _____
 Number of child of the mother now living including present birth _____

FATHER	MOTHER
FULL NAME	FULL NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born at _____
 on the _____ day of _____ 19____

• When there was no attending physician or midwife then the father, mother, grandparent, etc. should make this return.
 A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Give names added from a supplemental report)

Registered _____
 Filed _____

255-118 004-213
PLACE OF BIRTH

RECEIVED
MAY 12 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

111198

County of Bear Lake

City of Bloomington

No. _____ St. _____

BUREAU OF VITAL STATISTICS
Registration District No. 4-2

File No. 185

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Apr 18</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 4 Number of children of this mother now living, including present birth... 3

FATHER
FULL NAME Archie E Bee
RESIDENCE Bloomington Idaho
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ethylene Bateman
RESIDENCE Bloomington Idaho
COLOR White AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1 a. M. on the date above stated. Premature, about 6 years (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. O. Moore M.D.

(Physician or midwife)

Give names added from a supplemental report.

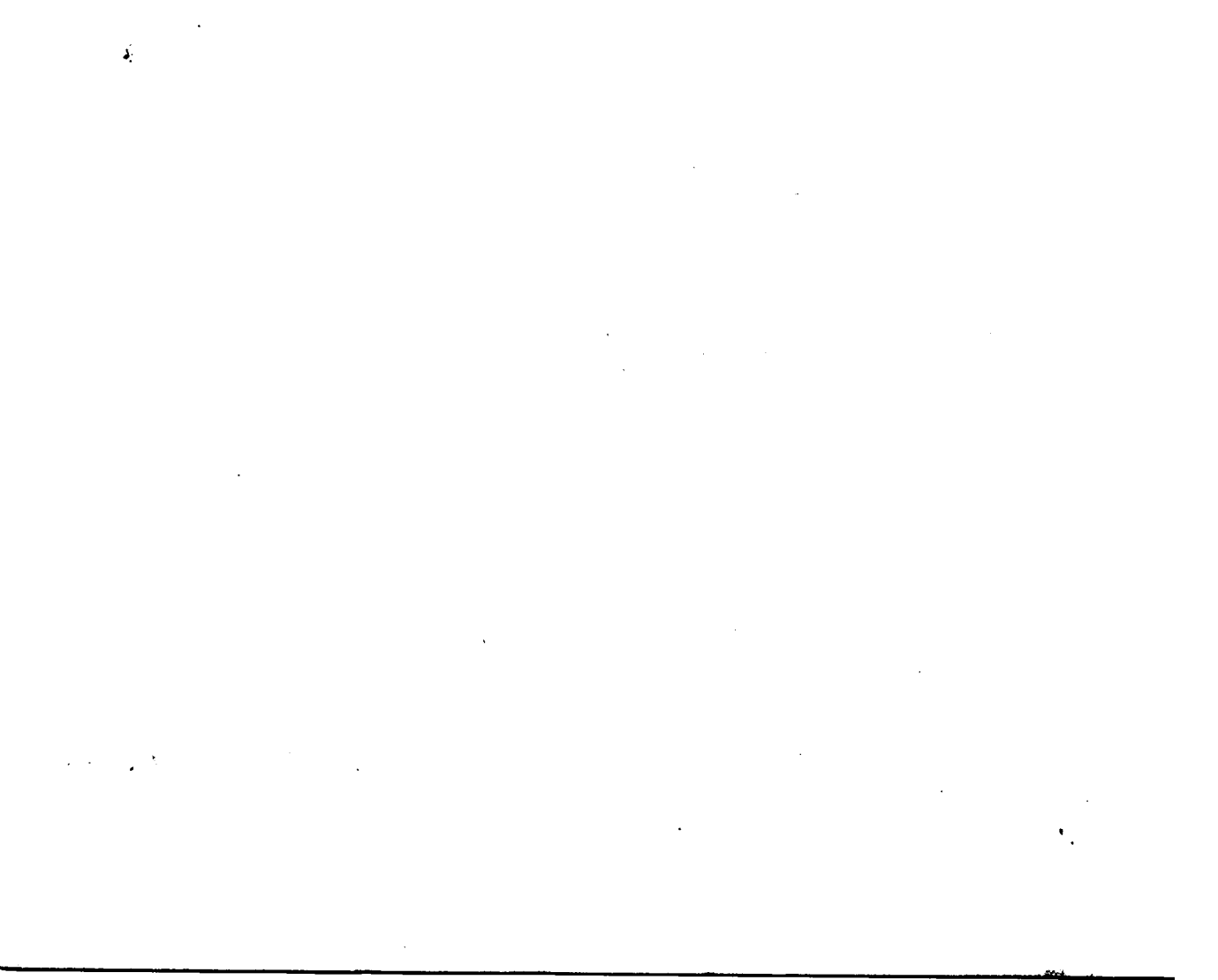
Address Paris Idaho

Filed 4-24 1923 Mrs. J. Skinner

Registrar.

Registrar.

PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

PLACE OF BIRTH _____ DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
County of Barnes RECEIVED
MAY 12 1923
Standard Certificate of Birth
City of Plummer Registered No. 111205
City of _____ (No. 46, 123) St.; _____ Ward) S
262-229005-253
FULL NAME OF CHILD Unnamed Bostwick {If child is not yet named, make supplemental report, as directed

Sex of Child <u>7</u>	Twin, triplet, or other? _____ (To be answered only in event of plural births)	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Apr 29</u> , 19 <u>23</u> (Month) (Day) (Year)
FATHER		MOTHER		
FULL NAME <u>Jerome Bostwick</u>		FULL MAIDEN NAME <u>Lottie Ketrach</u>		
RESIDENCE <u>Plummer Id.</u>		RESIDENCE <u>Plummer Id.</u>		
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)	
BIRTHPLACE <u>Miss</u>		BIRTHPLACE <u>Ohio</u>		
OCCUPATION <u>Farmer</u>		OCCUPATION <u>House wife</u>		
Number of children born to this mother, including present birth <u>1</u>		Number of children of this mother now living <u>none</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born at 12³⁰ M.,
on the date above stated. (Born alive or Stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. G. Nelson
Physician
(Physician or Midwife)

Given name added from a supplemental report _____, 19____

Address

Tedou, Wash.

Filed

May 1, 1923

4
META NO 3

side side to

(12)

1

1

LIVED **CERTIFICATE OF DEATH**
 1. PLACE OF DEATH *Bennwah* Registration District No. *46*
 County of *Bennwah* Registration District No. *2123*
 City of *Plummer* Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed Bostwick

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *41903*
 Registered No. *2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Infant
 (Write the word.)

6. DATE OF BIRTH *Apr 29 - 1923*
 (Month) (Day) (Year)

7. AGE *the born* IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE *Plummer Idaho*
 (State or Country)

10. NAME OF FATHER *Jerome Bostwick*

11. BIRTHPLACE OF FATHER *Idaho*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Lotter Ketch*

13. BIRTHPLACE OF MOTHER *Ohio*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. *May* 19 *23*
 Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Apr 29 1923*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *1923* to *1923*

that I last saw him alive on *1923*
 and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH was as follows:

*Protruding presentation
 causing strangulation*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*J. A. Nelson M. D.*19. (Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

757-216-009-813
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
JUN 7 1923
BUREAU OF VITAL STATISTICS

S

County of Bonner
City of Sandpoint
No. _____ St. _____
Hospital City Primary Registration District No. 2155
FULL NAME OF CHILD Stillborn

File No. 111274

Registered No. _____

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>5/16/23</u> 192 <u>...</u> (Month) (Day) (Year)
----------------------------	---	---	------------------------	---

What bactericidal solution was used in eyes? 0

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Edgar Noel Leger</u>	FULL MAIDEN NAME	<u>Norma Henrietta Hale</u>
RESIDENCE	<u>Sandpoint</u>	RESIDENCE	<u>Sandpoint</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>37</u> (Years)	AGE AT LAST BIRTHDAY	<u>26</u> (Years)
BIRTHPLACE	<u>Neb.</u>	BIRTHPLACE	<u>Idaho.</u>
OCCUPATION	<u>Miner</u>	OCCUPATION	<u>Haw.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 3 P. M.
on the date above stated. (Born alive or stillborn)

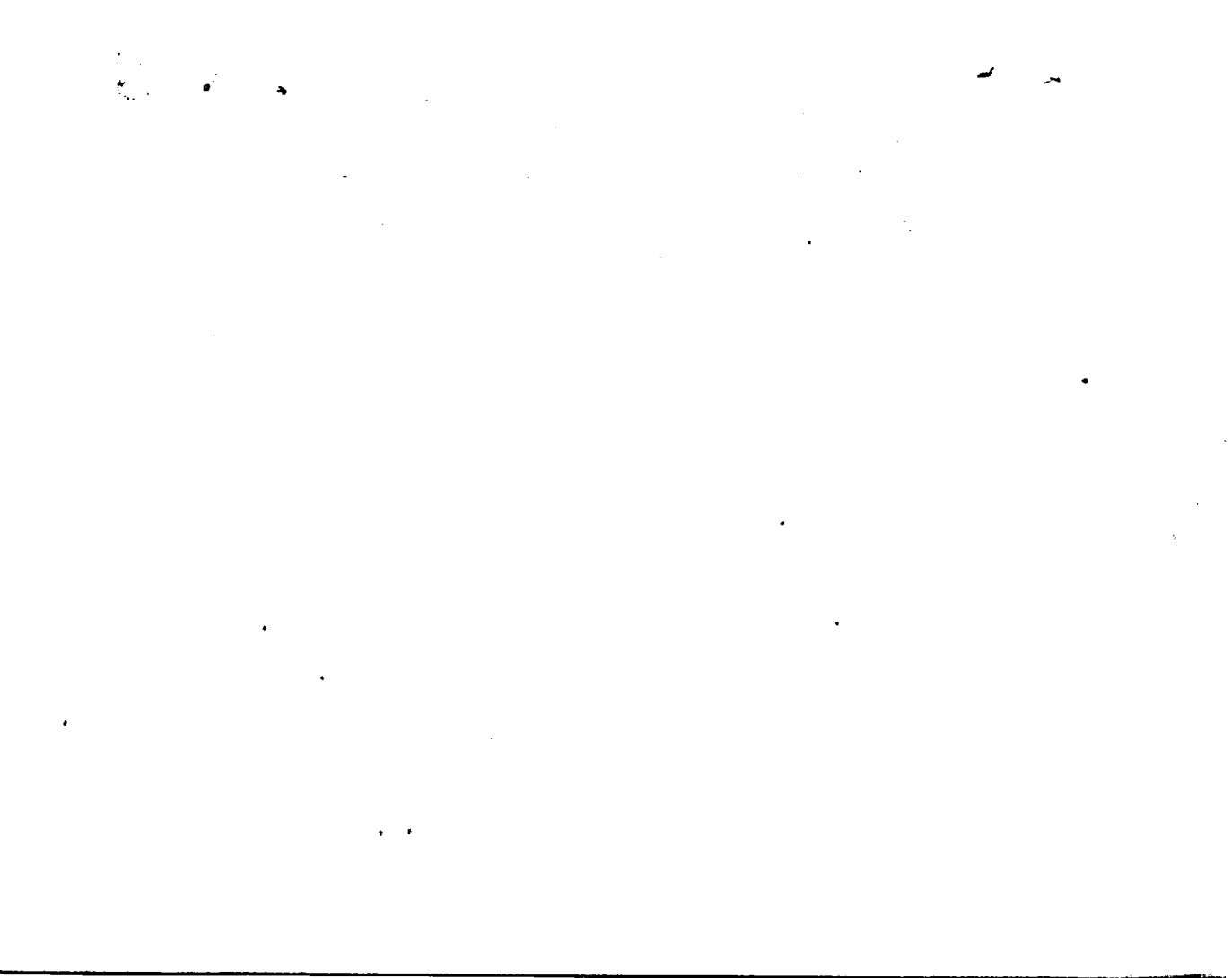
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature) N R Wallentine
M.D.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Sandpoint
Filed June 2 1923
Viola Allen
Deputy Registrar.



FORM V. S. No. 5-25 M. 1-19.

Dr. Wallentine

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78
 County of Bonner JUN 7 1923
 City of Sandpoint Primary Registration District No. 2155
 (St.)

File No. 41927
 Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

RECEIVED
JUN 7 1923
BUREAU OF VITAL
STATISTICS

2. FULL NAME

"Baby" Leger.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

5-16-23
 (Month) (Day) (Year)

7. AGE

still born
 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Infant.

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Edgar H. Leger.

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska.

12. MAIDEN NAME OF MOTHER

Norma Hale

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. H. Leger

(Address)

Salcha, Idaho.

15.

Filed May 17 1923

Viola Allen
 Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5-16-23
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

still born, to 19
 that I last saw h. still born alive on 19
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. Wallentine M. D.

5-17-23 (Address) Sandpoint, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenview Cemetery

5/17/1923

20. UNDERTAKER

ADDRESS

L. J. Moon

Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children as *Industrially employed, as At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

437-215014-229
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

111373

County of Canyon
City of Nampa
No. 107-12 Registration District No. 7 File No. 111373
Hospital _____ Primary Registration District No. 1006 Registered No. _____
FULL NAME OF CHILD not named McGrew
(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <input checked="" type="checkbox"/> and <input checked="" type="checkbox"/> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>5-15-1923</u> (Month) (Day) (Year)
----------------------------	--	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 6

FULL NAME <u>John M. McGrew</u>	FATHER	FULL MAIDEN NAME <u>May Skinner</u>	MOTHER
RESIDENCE <u>19th Ave. bet. 2 + 3rd St.</u>		RESIDENCE <u>19th Ave. bet. 2 + 3rd St.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Oklahoma City</u>		BIRTHPLACE <u>Bea Lake, Idaho</u>	
OCCUPATION <u>Logger.</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 4:30 A.M.
on the date above stated. (born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

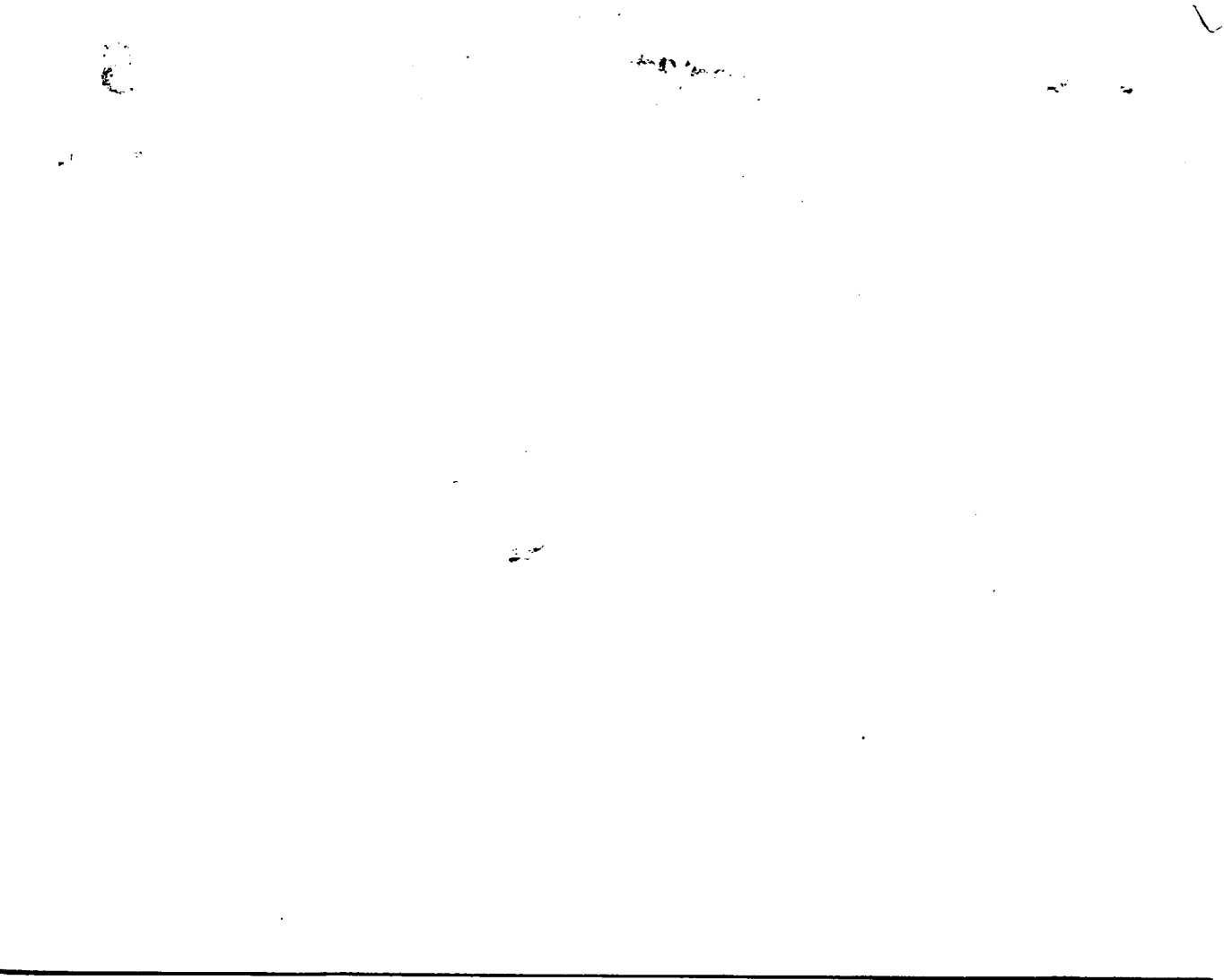
(Signature) Horace P. Belknap

Give names added from a supplemental report.
_____, 19____

Registrar.

(Physician or midwife)
Address Nampa, Idaho
Filed May 4 1923 Pearle Dodds
Registrar.

WRITE PLAINLY WITH LEADING INK—THIS IS A PERMANENT RECORD
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 41978
Registered No.

1. PLACE OF DEATH

County of Cam Registration District No. 7
City of Nampa Primary Registration District No. 1006
City of Nampa (No. 1006) St. If death occurs away from usual residence, give facts called for under special information.
BUREAU OF VITAL STATISTICS

2. FULL NAME

Infant Mc Grew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

6 (Month) 15 (Day) 1923 (Year)

7. AGE

1 Yrs. 1 Mos. 1 ds.IF LESS than 1 day
how many 1 hrs.
or 1 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John M. McGrew

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

May Skinner

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs John McGrew
(Address) Nampa Idaho

15.

Filed June 4 1923 Pearle D. Dicks
Local Registrar

MEDICAL CERTIFICATE OF DEATH

189-6

16. DATE OF DEATH

6 (Month) 13 (Day) 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn(Duration) Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed)

Horace P. Belknap M. D.

(Address)

Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa

DATE OF BURIAL

5/13 1923

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

255-128014-666
PLACE OF BIRTH

RECEIVED
MAY 15 1923
BUREAU
STATE
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon
City of Houston
No. Rur. No. 1. St.

BUREAU
ST
Registration District No. 3 File No. 111415

Hospital _____ Primary Registration District No. 2005 Registered No. 82

FULL NAME OF CHILD Baby Benton
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ } and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 28</u> 1923 (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Asa B. Benton</u>	<u>Houston - Idaho</u>	<u>Rose Elna Hood</u>	<u>Houston, Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>New York</u>		BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Farming</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born at 4:30 a. m.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

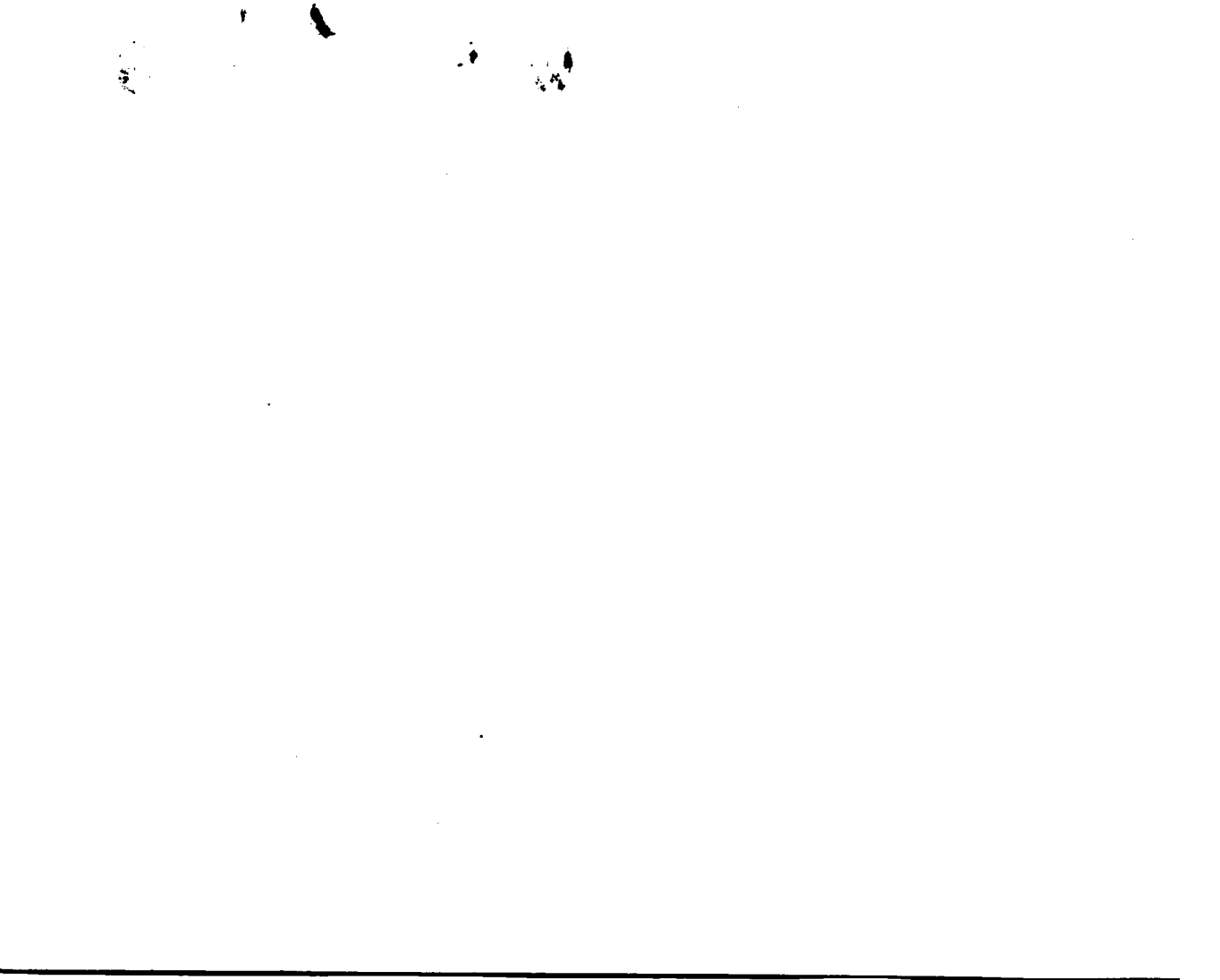
(Signature) John H. Meyer M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Caldwell - Idaho

Filed April 28 1923 John H. Meyer
Registrar.



432-209 014-665
PLACE OF BIRTHCOUNTY OF Canyon MAY 12 1923
CITY OF Wilder BUREAU OF VITAL STATISTICS
REGISTRATION DISTRICT NO. 3

Form V. S. No. 11-C-25m-7-21-19

File No. 111428

No. _____ St. _____

HOSPITAL Home PRIMARY REGISTRATION DISTRICT NO. 2007 REGISTERED NO. 30FULL NAME OF CHILD Baby M. KinneySEX OF CHILD Female TWIN Triplet and in order of birth Legitimate? Yes Date of Birth Mar 9 1923
(To be answered only in event of plural births) (Month) (Day) (Year)FATHER
FULL NAME W. R. M. Kinney
RESIDENCE Wilder Ida
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Marian Ind.
OCCUPATION LaborerMOTHER
FULL MAIDEN NAME Emma Owen
RESIDENCE Wilder Ida
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Beatrice Nebraska
OCCUPATION HousewifeNumber of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 10 30 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. R. M. Kinney

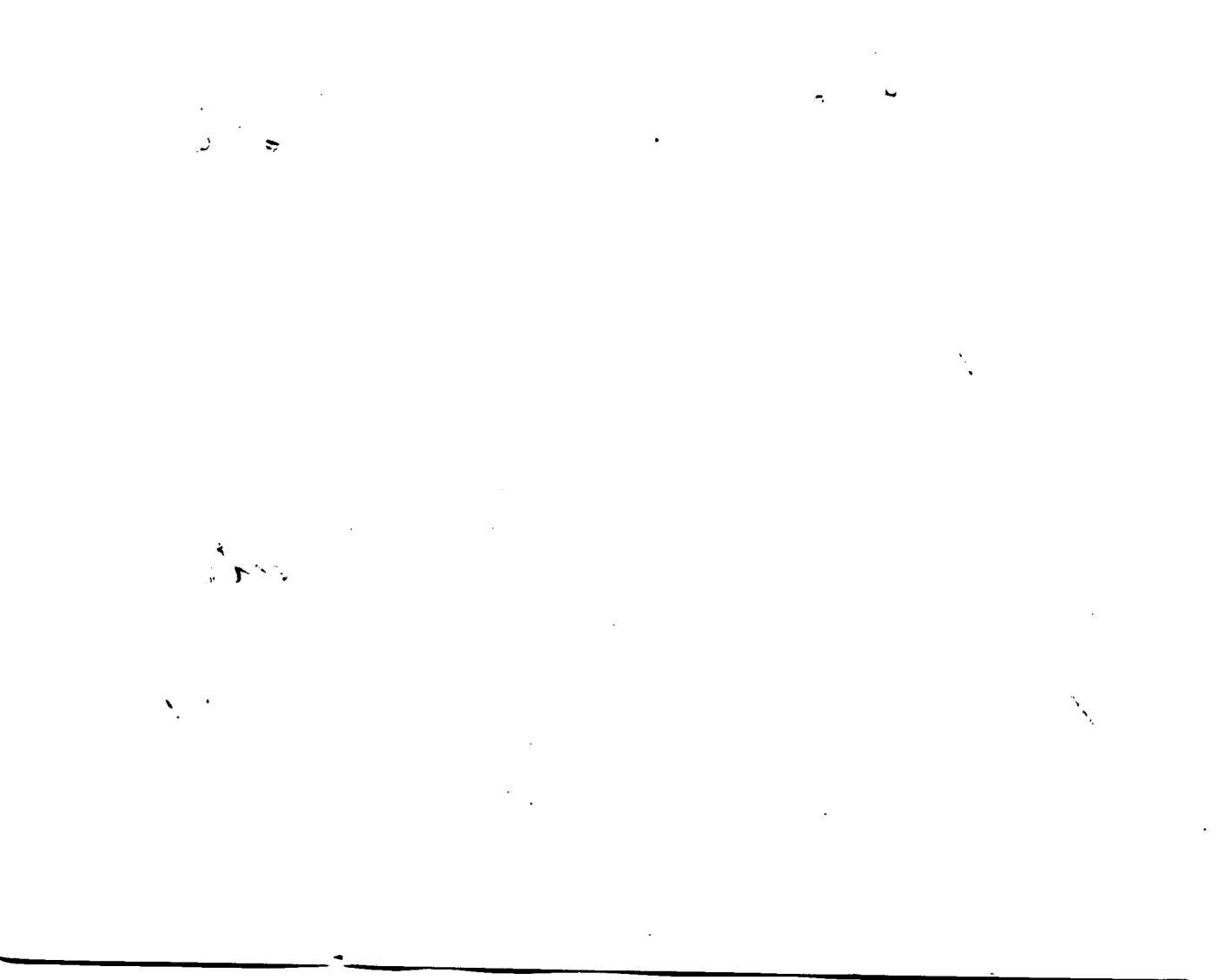
(Physician or midwife)

Given names added from a supplemental report.

19

Address Wilder IdahoFiled 5-8 1923Registrar K. R. Waldorf

Registrar



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon District No. 3
City of Wilder Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby McKinneyState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 41691Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

at home
(Write the word.)

6. DATE OF BIRTH

Mar 9 1923
(Month) (Day) (Year)

7. AGE

Still born
Mo. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at home

9. BIRTHPLACE

(State or Country)

Wilder Ida

10. NAME OF FATHER

W. B. McKinney

11. BIRTHPLACE OF FATHER

(State or Country)

Marian Ind.

12. MAIDEN NAME OF MOTHER

Emma Owen

13. BIRTHPLACE OF MOTHER

(State or Country)

Beatrice Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. B. McKinney

(Address)

Wilder Idaho

15.

Filed April 11 - 1923John V. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 9 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 9 1923, to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. B. McKinney M. D.
Mar 1923 (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wilder Ida

DATE OF BURIAL

3-9-1923

20. UNDERTAKER

W. B. McKinney

ADDRESS

Caldwell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

County of Lancaster

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

City of Soda Springs

CERTIFICATE OF BIRTH

S 111453
File No.

253-230015-791
No. St.

Registration District No. 82

Primary Registration District No. 2159

Registered No. 17

Hospital

Full Name of Child Kathryn Kelly

SEX OF CHILD <u>Female</u>	Twin Triplet or other? <u>Yes</u> (To be answered only in event of plural births)	Number in order of birth <u>1st</u>	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>April 30, 1923</u> (Month) (Day) (Year)
FULL NAME <u>Barbara Kelly</u>	FATHER		FULL MAIDEN NAME <u>Kathryn Pratt</u>	MOTHER
RESIDENCE <u>Soda Springs</u>			RESIDENCE <u>Soda Springs</u>	
COLOR <u>Wh.</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)		COLOR <u>Wh.</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Utah</u>			BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Civil Engineer</u>			OCCUPATION <u>Wife</u>	

Number of child of this mother, including present birth. 2nd Number of children of this mother now living, including present birth. 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was 5 P. M
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ellis R. Keesley

Given names added from a supplemental report.

Ellis Keesley 19
Soda Springs
Registrar

Address Soda Springs, Idaho
Filed May 16, 1923
Ellis R. Keesley
Registrar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. JUN 1 1923
County of Blaine Registration District No. 8.6
City of Soda Spring Primary Registration District No. 2159
(No. St.)

File No. 41986
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH.

April 30 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

7. AGE

1 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day
how many 1 hrs. or
1 min.?

that I last saw h. 1 alive on 191

and that death occurred on the date stated above, at 191 M.

The CAUSE OF DEATH* was as follows:

Premature - Still Born

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Soda Spring Id

10. NAME OF FATHER

Conrad Kelly

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Kathryn Brall

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edith Kelly
(Address) Soda Spring Id

15.

Filed

April 30 191 23 Edith Kelly
Local Registrar

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Soda Spring Id April 30 191 23

20. UNDERTAKER

ADDRESS

E. D. Whelan Soda Spring

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

819-1181027-813

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

JUN 6 1923

CERTIFICATE OF BIRTH

111544

County of Gem

City of _____

No. _____ St. _____

BUREAU OF VITAL
STATISTICS

No. 6

File No. _____

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD

William Marvon Hart

(Certificate of no value without full name of child.)

Sex of
Child

Male

Twin
Triplet
or other?

— and —

Number
in order
of birth

—

Legiti-
mate?

yes

Date of
birth

5-18- 1923

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... 5

Number of child of this mother now living, including present birth... 7

FULL
NAME

FATHER

Wm. H. Hart

FULL
MAIDEN
NAME

MOTHER

Alice Hall

RESIDENCE

Emmett

RESIDENCE

same

COLOR

white

AGE AT LAST
BIRTHDAY

49

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

41

(Years)

BIRTHPLACE

Kans

BIRTHPLACE

West Virg

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was...
on the date above stated.

stillborn

at... 11 A. M.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Benton O. Clark

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

6, 5 1923

J. H. Reynolds

Registrar.

Registrar.

OK B-1LN

012190 HIA

S

CHIEF OF POLICE (COP)

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 6/9 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth	{	CITY <u>Emmett</u>	FILE NO. <u>111544</u>
		ST. _____	DATE OF BIRTH <u>18 May</u>
		COUNTY <u>Idaho</u>	SEX OF CHILD <u>Male</u>
		FATHER <u>William Hart</u>	MOTHER <u>Alice Hall</u> (Maiden Name)

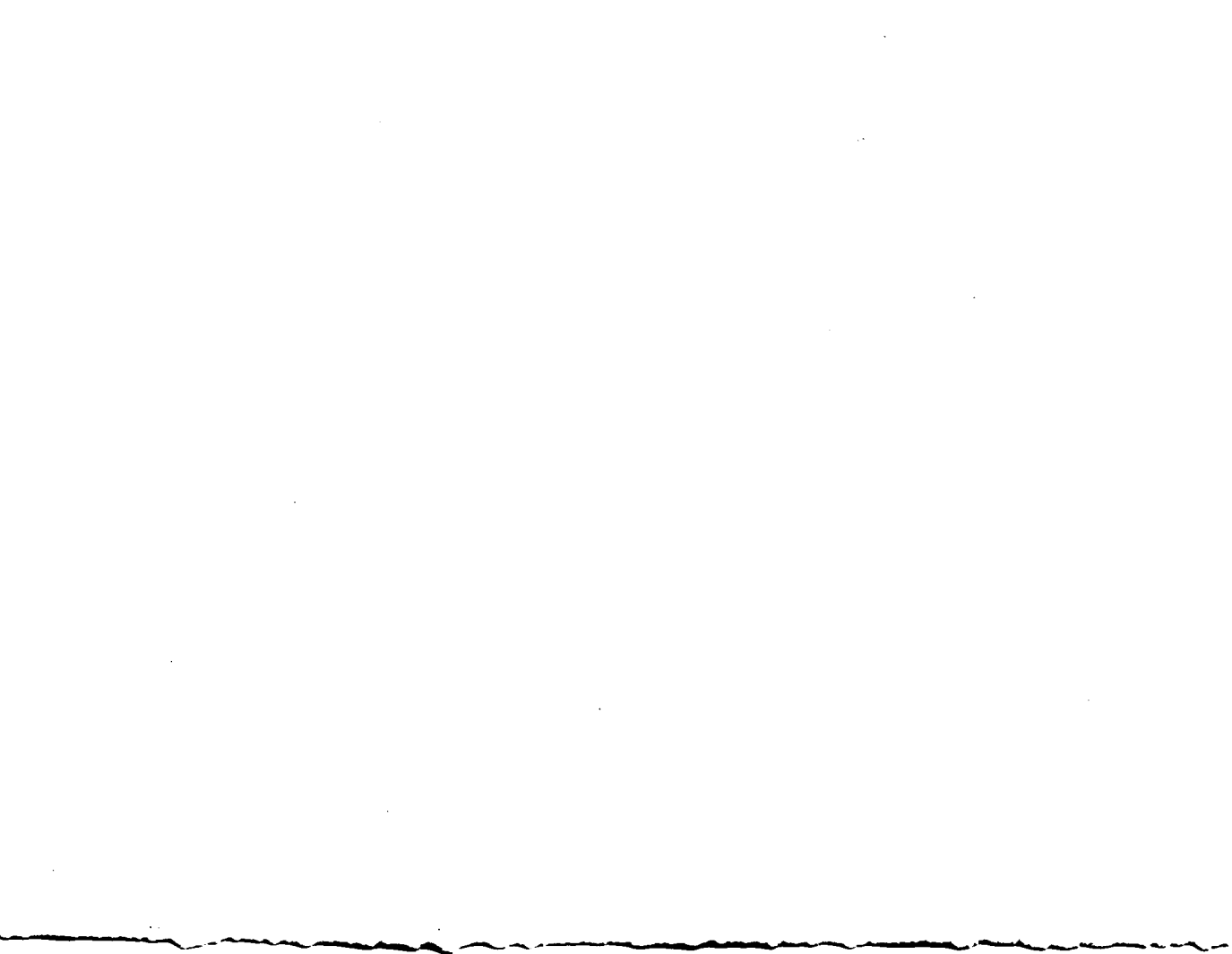
I HEREBY CERTIFY that the child herein described has been named:

William Marvin Hart

Mrs. William Hart

Signature of Father or Mother.

RECEIVED
JUN 22 1923
BUREAU OF VITAL
STATISTICS



556-210123-229
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. 9. No. 11-25m-6-18-18

BUREAU OF VITAL STATISTICS

JUN 6 1923

CERTIFICATE OF BIRTH

BUREAU OF VITAL
STATISTICS

Registration District No.

File No.

111516

County of IdahoVicinity of Emmett
City of

No. _____ St. _____

Primary Registration District No. _____

Registered No. _____

Hospital _____

Full Name of Child Unnamed Stillborn newell

SEX OF CHILD <u>Fe</u>	Twin Triplet or other? <u>No</u> (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	DATE OF BIRTH <u>May 14 23</u> (Month) (Day) (Year)
FATHER			MOTHER		
FULL NAME <u>Wm newell</u>			FULL MAIDEN NAME <u>Mary Skillinge</u>		
RESIDENCE <u>Emmett</u>			RESIDENCE <u>Emmett</u>		
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>49</u> (Years)		COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)	
BIRTHPLACE <u>Missouri</u>			BIRTHPLACE <u>Nebraska</u>		
OCCUPATION <u>Rancher</u>			OCCUPATION <u>Housewife</u>		

Number of child of this mother, including present birth. 7 Number of children of this mother now living, including present birth. 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still born at 2 PM M on the date above stated.
(Born alive or stillborn)(Signature) A. G. Byrd, M.D.

(Physician or midwife)

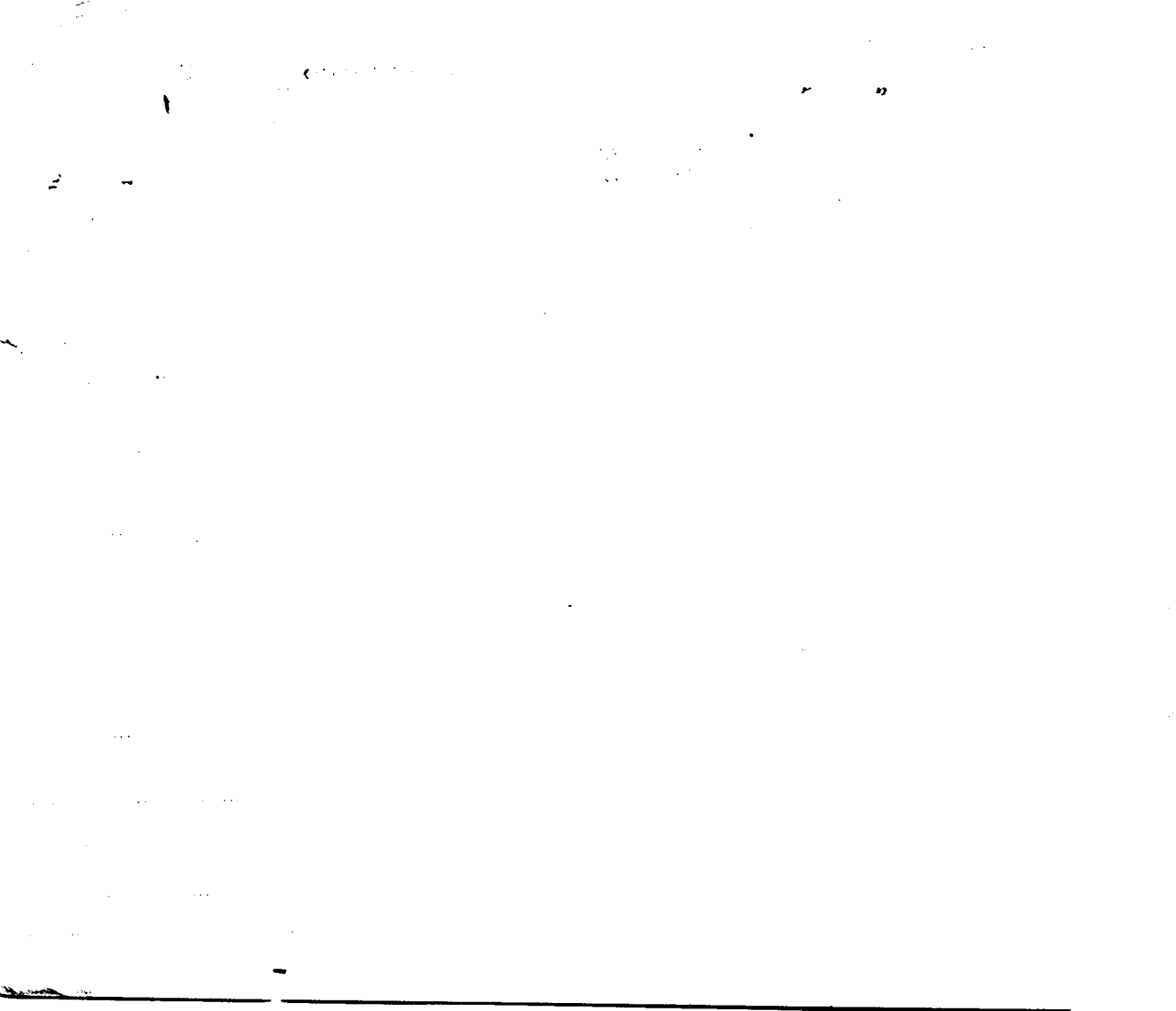
Given names added from a supplemental report.

Address Emmett 2d aveFiled 5/14 1923

Registrar

Registrar

-on one child at birth, a SEPARATE RETURN must be given for each and every child of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 12011

1. PLACE OF DEATH

County of Lem
City of Emmett

RECEIVED

District No. 6

Registration District No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant daughter H. M. Newell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

May 14 1923
(Month) (Day) (Year)

7. AGE

new born

IF LESS than 1 day

how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. M. Newell

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Almedia Skillings

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. M. Newell

(Address)

15.

Filed

5/14 1923

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH 189-6

16. DATE OF DEATH

May 14 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 14 1923 to 5/14 1923
that I last saw him alive on 1923

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

A. G. Boyd M. D.

5/14 1923

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sweet Idaho

DATE OF BURIAL

5/15 1923

20. UNDERTAKER

W. Bucknum

ADDRESS

Emmett Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

795-213-025-238
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho
City of Marguerite
No. 103 District No. 103 File No. 111590
Hospital Stillborn Primary Registration District No. 2181 Registered No. 26
FULL NAME OF CHILD Stillborn
(Certificate of no value without full name of child.)

RECEIVED
JUN 1 1923
BUREAU OF VITAL
STATISTICS

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u> (To be answered only in event of plural births)	and { Number in order of birth }	Legiti-mate? <u>yes</u>	Date of birth <u>May 13</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	----------------------------------	-------------------------	--

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth... 1..... Number of child of this mother now living, including present birth... 0.....

FULL NAME <u>Frank M. Gregg</u>	FATHER	FULL MAIDEN NAME <u>Jennie Schulte</u>	MOTHER
RESIDENCE <u>Marguerite Ida</u>		RESIDENCE <u>Marguerite Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9-9 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

B. Chipman
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

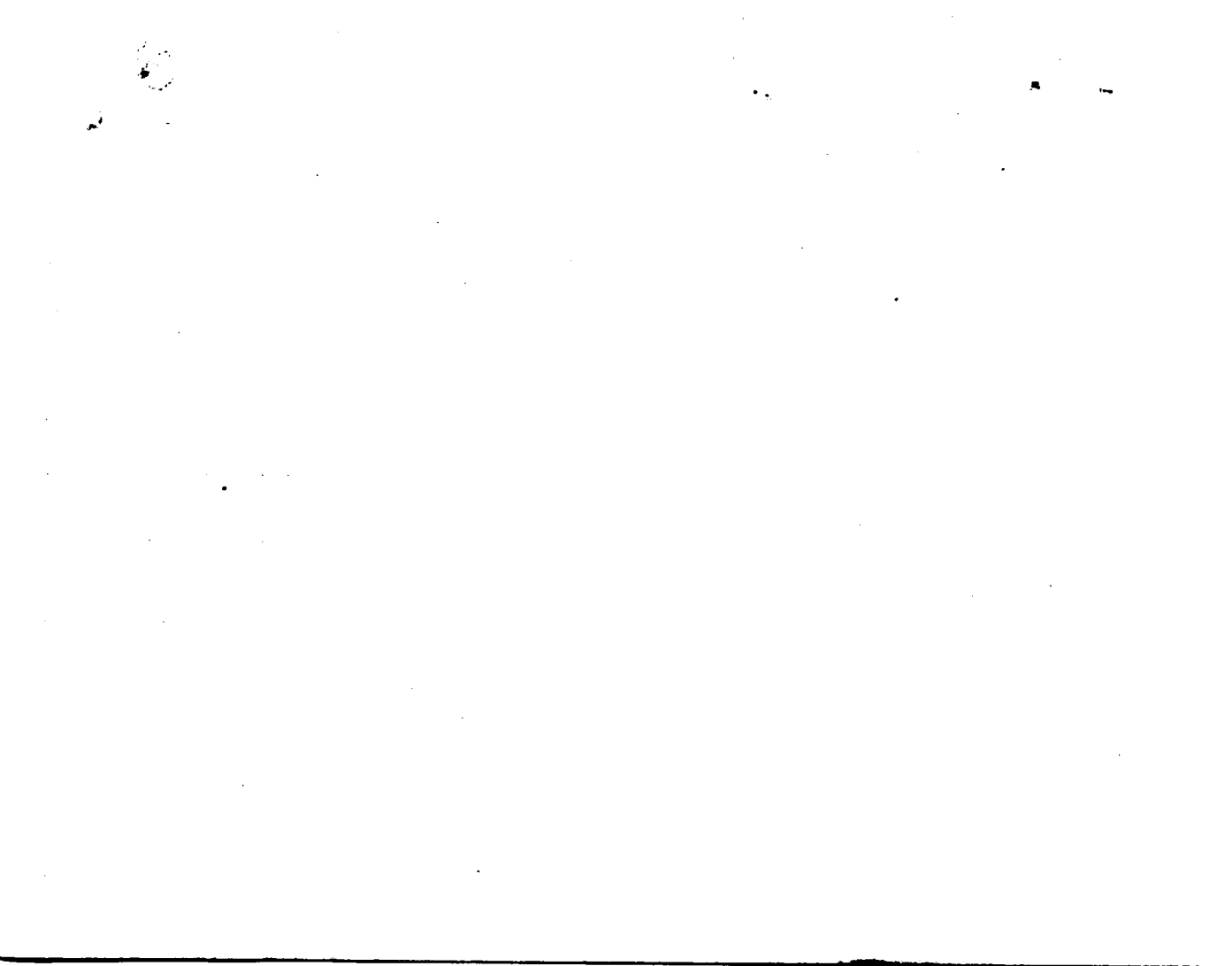
Marguerite Ida

Filed

June 1, 1923 J. S. Stockton

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

JUN 1 1923 Registered District No.

BUREAU OF VITAL STATISTICS Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42015
Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many 0 hrs.
or 0 min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

June 1, 1923

98

Sticks

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 13 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:Period of gestation about
9 months

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/25 1923 (Address) Chungville, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chungville, Ida.

5/13 1923

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

855-201-029-366
PLACE OF BIRTH

RECEIVED
MAY 15 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Latah
City of Harvard
No. _____ St. _____ Registration District No. 65 State File No. 111636
Hospital _____ Primary Registration District No. 2145 Local Registrar's No. _____
FULL NAME OF CHILD Clara May Hengen

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>May 1</u> , 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---------------------------------------	-----	---	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER FULL NAME <u>William H. Hengen</u> RESIDENCE <u>Harvard</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>42</u> (Years) BIRTHPLACE <u>Minnesota</u> OCCUPATION <u>Farmer</u>	MOTHER FULL MAIDEN NAME <u>Minnie E. Coffman</u> RESIDENCE <u>Harvard</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>38</u> (Years) BIRTHPLACE <u>Virginia</u> OCCUPATION <u>Housewife</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:45 A. M. on the date above stated.

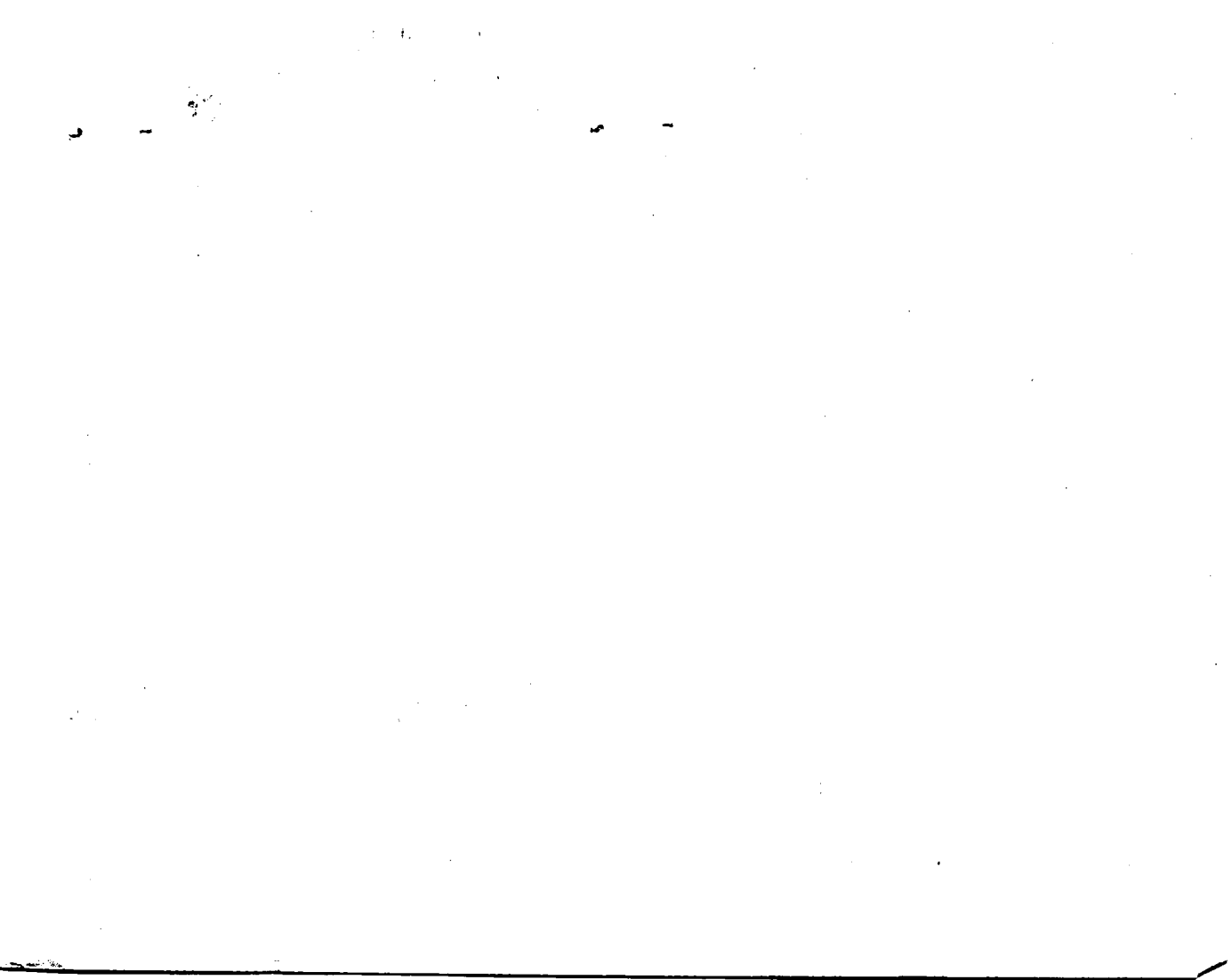
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. R. Thompson
(Physician or midwife)

Give names added from a supplemental report.
_____, 192____

Address Pottsville
Filed May 8, 1923 Dr. J. R. Thompson
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-1

RECEIVED
MAY 15 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

42028

1. PLACE OF DEATH
County of Latah
City of Harvard (No. _____ St.)
Registration District No. 65
Registration District No. 2145

File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara May Henryon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH
May 1 1923
(Month) (Day) (Year)

7. AGE
Yrs. 0 Mos. 0 ds. 0
IF LESS than 1 day how many 0 hrs. or 0 min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9. BIRTHPLACE

(State or Country)

Harvard

10. NAME OF FATHER

William H. Henryon

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Minnie L. Coffman

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Henryon(Address) Harvard Idaho

15. Filed May 3rd 191 1923 J. M. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

May 1 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1923 to May 1923

that I last saw him alive on May 1923

and that death occurred on the date stated above, at 3:45 AM.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory (Secondary) (Dystocia) Placenta Previa

(Duration) yrs. mos. ds.

(Signed) J. M. Thompson M. D.
5/3/1923 (Address) Booth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days In the State. yrs. mos. days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
May 3rd 1923

20. UNDERTAKER

ADDRESS

ParentsHarvard

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 8 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

168-14-029-753
PLACE OF BIRTH

RECEIVED

MAY 12 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Moscow

No. _____ St. _____

Registration District No. 61

File No. 111649

Hospital _____

Primary Registration District No. 1011

Registered No. 49

FULL NAME OF CHILD

Baby Johnson

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>11th Jan 1923</u> (Month) (Day) (Year)
-----------------------	---	------------------------	---

What bactericidal solution was used in eyes? No

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FULL NAME Arthur Benjamin Johnson

FULL MAIDEN NAME Heley Abel Pelot

RESIDENCE Moscow

RESIDENCE Moscow

COLOR white AGE AT LAST BIRTHDAY 34 (years)

COLOR _____ AGE AT LAST BIRTHDAY 33 (years)

BIRTHPLACE Graham, Neb

BIRTHPLACE Idaho Falls Ida

OCCUPATION Student

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 1215 P M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. D. Magee
Physician
(Physician or midwife)

Give names added from a supplemental report.

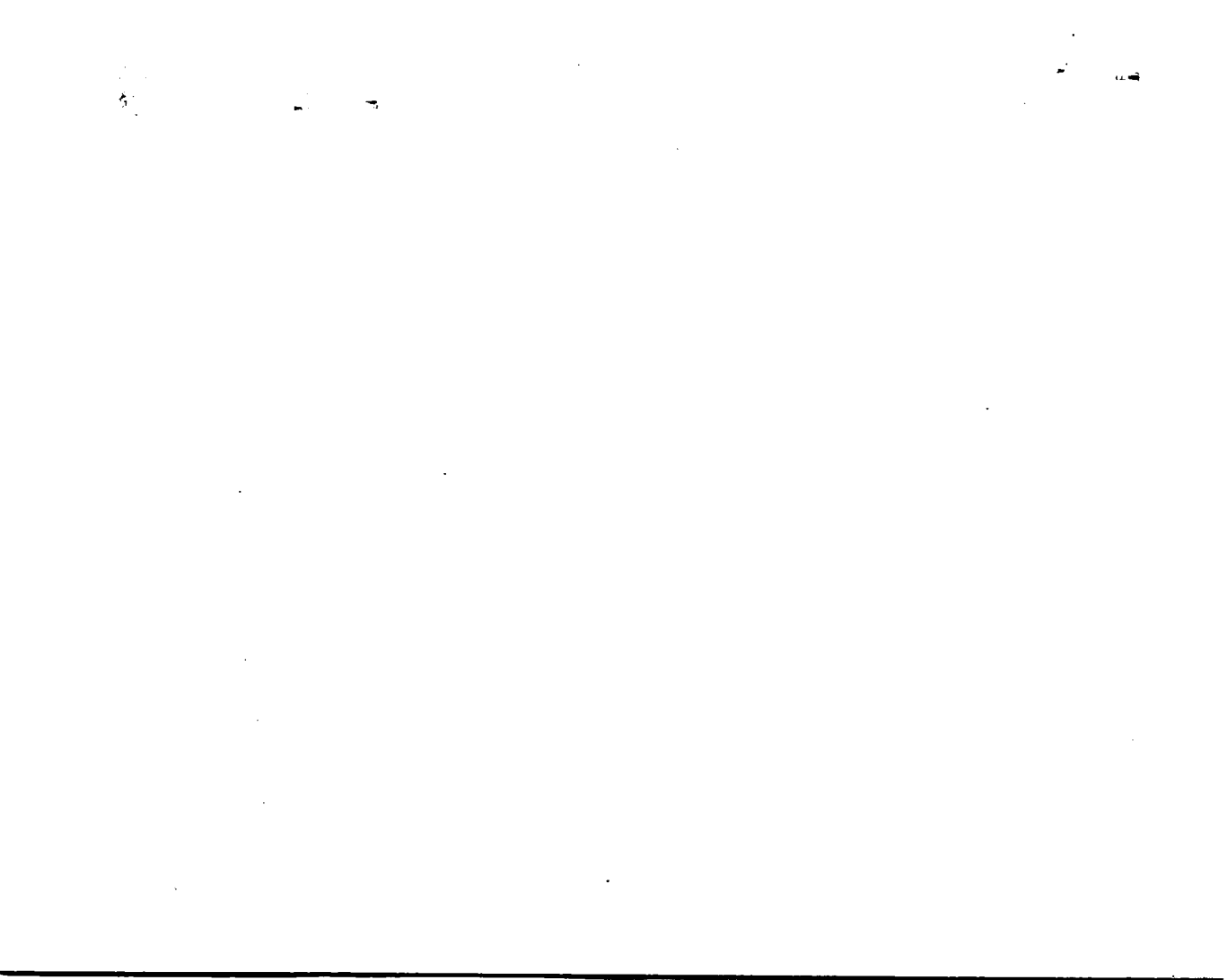
Address _____

_____, 19____

Filed April 8 1923 M. H. Coarthers

_____, Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Latah Registration District No. 601
 City of Moreau Primary Registration District No. 1011 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Johnson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40900
 Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
 (Write the word.)

6. DATE OF BIRTH

January 11 1923
 (Month) (Day) (Year)

7. AGE

Stillborn IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Latah

10. NAME OF FATHER

Arthur Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Wahoo Neb

12. MAIDEN NAME OF MOTHER

Helen Ad Pelot

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho Falls Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. Magle
Moreau

15.

Filed Jan 12 1923

W. H. Carithers
 Local Registrar

16. DATE OF DEATH

Stillborn
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
 that I last saw him..... alive on 19.....
 and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Immaturity 7 1/2 mo

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

11 1923

(Address)

E. Magle
Moreau

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MoreauJan 12 1923

20. UNDERTAKER

ADDRESS

E. R. ShortMoreau

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

314-128018-212

County of... Clear Lake

City of... Sutter

No. St.

Hospital

FULL NAME OF CHILD

RECEIVED
MAY 12 1923BUREAU OF VITAL
STATISTICS

Registration District No. 90

Primary Registration District No. 3168

Francis Leo Campbell

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTHS 111677
File No.

Registered No. 19

Sex of Child	Twin Triplet or other?	and { Number in order of birth	Legiti- mate?	Date of Birth
Boy	1	1	Yes	1/25 23
	(To be answered only in event of plural births)			(Month) (Day) (Year)

FULL NAME	FATHER
Edmund L. Campbell	
RESIDENCE	
Sutter	
COLOR	AGE AT LAST BIRTHDAY
White	26
	(Years)
BIRTHPLACE	
Idaho	
OCCUPATION	
Labourer	

FULL MAIDEN NAME	MOTHER
Indie Baker	
RESIDENCE	
Sutter	
COLOR	AGE AT LAST BIRTHDAY
White	21
	(Years)
BIRTHPLACE	
Idaho	
OCCUPATION	
Housewife	

Number of child of this mother, including present birth.... 2. Number of children of this mother now living, including present birth.... 1.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was at
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)
Edmund L. Campbell
(Physician or midwife)

Given names added from a supplemental report.

..... 19

Address

Filed May 15 1923

Registrar

Registrar

THE
FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5

RECEIVED
MAY 17 1923
STATE OF IDAHO
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41988
Registered No. 14

1. PLACE OF DEATH
County of Clearwater
City of Shippu
(No. 90 St.)
Primary Registration District No. 2168
2. FULL NAME John Doe Campbell

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH 1 25 1923
(Month) (Day) (Year)

7. AGE stillborn
IF LESS than 1 day how many yrs. mos. ds. hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Shippu Idaho

10. NAME OF FATHER Edward L. Campbell

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Verdie Baker

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)
(Address)

15. Filed May 1 1923 J. M. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 25 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from stillborn
that I last saw him alive on 191
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

stillborn as a result of placenta previa.
apoplexy
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. M. Smith M. D.
19 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
191

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero-gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

386-218-018-823
PLACE OF BIRTH

County of Clearwater

City of Leone RFD

No. St.

Hospital

FULL NAME OF CHILD

RECEIVED
MAY 12 1923
BUREAU OF VITAL
STATISTICS

Registration District No. 90

Primary Registration District No. 2168

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-9-8-17

S 111679

File No. 7

Registered No. 21

Sex of Child <u>girl</u>	Twin Triplet or other? <u>X</u>	and { Number in order of birth <u>X</u>	Legitimate? <u>Yes</u>	Date of Birth <u>3/15</u> 19 <u>23</u> (Month) (Day) (Year)
--------------------------	---------------------------------	---	------------------------	--

FULL NAME <u>Fred C. Choate</u>	FATHER
RESIDENCE <u>Leone RFD</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY ... <u>35</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Maudie Wolf</u>	MOTHER
RESIDENCE <u>Leone RFD</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY ... <u>35</u> (Years)
BIRTHPLACE <u>Mo.</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was at 5:30 P.M. on the date above stated. (Born ~~alive~~ stillborn)

{ When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

Given names added from a supplemental report.

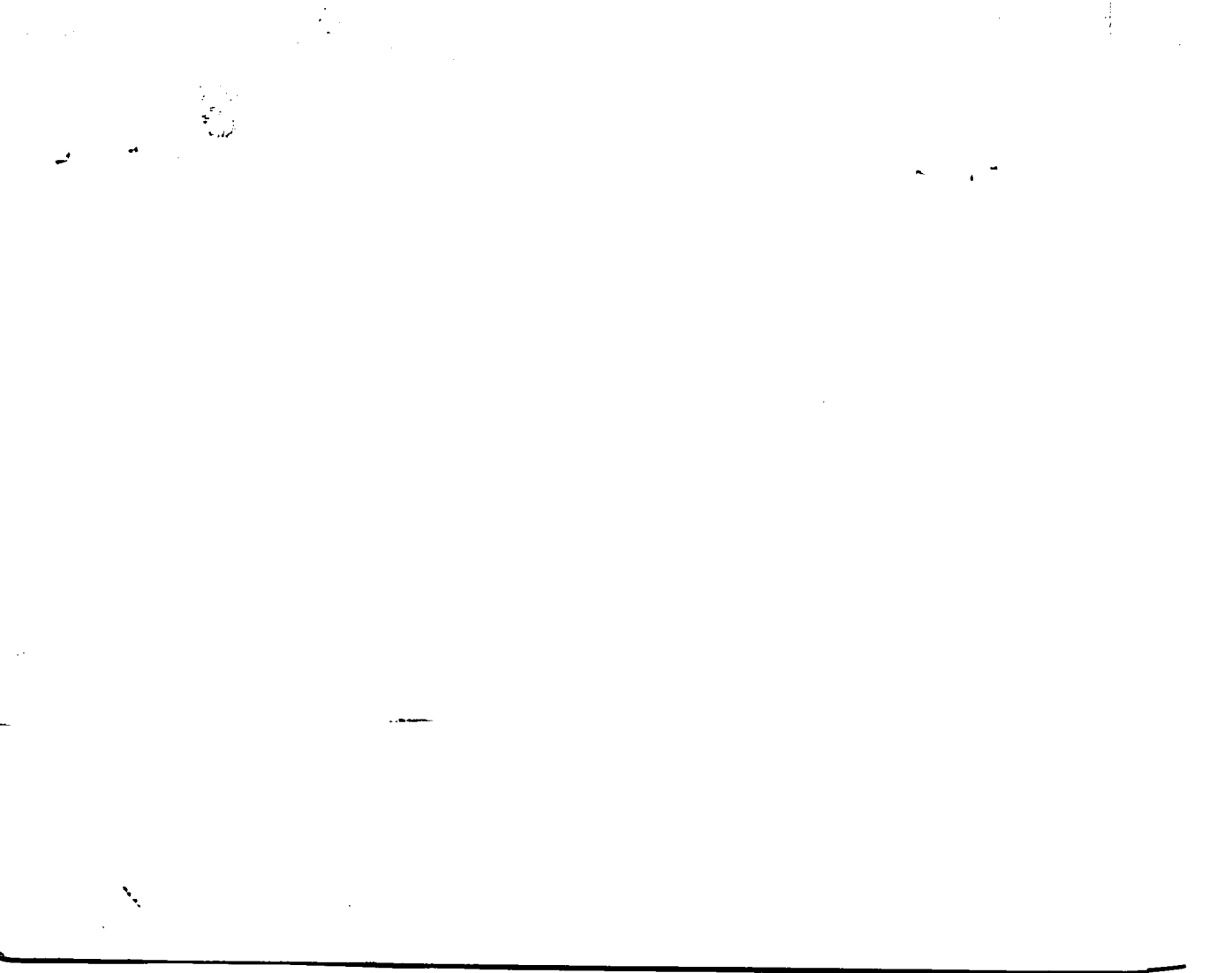
(Signature) E. E. McFarrell
(Physician or midwife)

Address Infirmary

Filed May 12 1923

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

1. PLACE OF DEATH

County of Clearwater

City of Lenoir

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 90

Primary Registration District No. 2168

(No. 1 St.)

Maude Hall

RECEIVED

MAY 21 1923

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41987

Registered No. 72

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Boy

White

(Write the word.)

6. DATE OF BIRTH

3/18

1923

(Month)

(Day)

(Year)

7. AGE

Stillborn

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Fred C. Choate

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Maude Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed May 1 1923

J. M. Fain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3/18

1923

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to

191.,

that I last saw h. alive on 191.,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Breach - asphyxia

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Edw. M. D.

19.

(Address)

Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

if not at place of death?

Former or

usual residence

In the

State

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191.

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

624

552-108-073-419

PLACE OF BIRTH

RECEIVED
JUN 7 1923
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison
City of Hubbard

No. St. Registration District No. 100 State File No. 111696

Hospital..... Primary Registration District No. 2178 Local Registrar's No. 419

FULL NAME OF CHILD Baley Nestor
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>4-8-1923</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth <u>7</u>		Number of child of this mother now living, including present birth <u>4</u>	
FULL NAME <u>Louis M Nestor</u>	FATHER	FULL MAIDEN NAME <u>Pearl E Martin</u>	MOTHER
RESIDENCE <u>Hubbard</u>		RESIDENCE <u>Hubbard</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Nebraska</u>		BIRTHPLACE <u>Missouri</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was mailed for Stillborn at 3:45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Louis M. Nestor

(Physician or midwife) Reuben L. Idaho

Give names added from a supplemental report.
....., 192.....

Address.....
Filed 5/7/23 192.....
Registrar. W. Young

Registrar.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Madison Registration District No. 100
 City of Hiibbard Registration District No. 2178
 St. Nebraska

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baker Nester

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 42053Registered No. 102

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
~~OWED OR DIVORCED~~ Single
 (Write the word.)

6. DATE OF BIRTH

4 - 8 - 1923
 (Month) (Day) (Year)

7. AGE

Steele

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hiibbard
Madison Co. Ida

10. NAME OF FATHER

Louis M. Nester

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Pearl E. Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 4/9 19 23

W. C. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 - 8 - 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4 - 8 - 1923 to 4 - 8 - 1923

that I last saw Steele 1923

and that death occurred on the date stated above, at Steele M.

The CAUSE OF DEATH* was as follows:

Steele
(due to frost in Nebraska Card)

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

4/9 19 23

(Address) Rehoboth, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Baker
no undertaker

4/9 19 23

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

694-166-033-255
PLACE OF BIRTH
County of Madison
City of Rexburg
No. 71-5-1st West
Hospital.....
Primary Registration District No. 2178 Local Registrar's No. 433
FULL NAME OF CHILD Stillborn
(Certificate of no value without full name of child.)

RECEIVED
JUL 7 1923
BUREAU OF VITAL STATISTICS
DEPT. OF IDAHO
PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
111711

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth 4-16- 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none
Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4
FATHER FULL NAME Gustav E. Widsten MOTHER FULL MAIDEN NAME Emma Irene Benson
RESIDENCE Rexburg RESIDENCE Rexburg
COLOR White AGE AT LAST BIRTHDAY 42 (Years) COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Norway BIRTHPLACE Utah
OCCUPATION Jeweler OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11 P. on the date above stated.
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
(Signature) John A. Rich
(Physician or midwife)
Address Rexburg Idaho.
Filed 5/30 1923
Registrar. Registrar.

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 6/9 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Redburg
ST. _____
COUNTY Madison
FATHER _____

FILE NO. 111711
DATE OF BIRTH _____
SEX OF CHILD Male
MOTHER Cornealine Benson
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

VED
1923
OF VITAL
STATISTICS

Steel Boone
G. E. H. H. H. H. H.

Signature of Father or Mother.



STATE OF IDAHO

DEPARTMENT OF AGRICULTURE

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42054

Registered No. 103

1. PLACE OF DEATH
 County of Madison Registration District No. 100
 City of Reeseburg Registration District No. 278

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
 (Write the word.)

6. DATE OF BIRTH

4 16 1923
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many hrs.
 or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Lester E. Widsten

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Emma Rinnion

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester E. Widsten

(Address)

15.

Filed

4/16 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 16 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
4-16-1923 to 4-16-1923

that I last saw him alive on Shelton 19
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Strangulation Umbilical Cord

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/17 1923

(Address)

Lester E. Widsten
Reeseburg, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection) need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1637
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
613-104-013-155
County of Madison

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

CERTIFICATE OF BIRTH

City of Salem

JUN 7 1923

No. St.

Registration District No. 100

State File No. 111735

Hospital

Primary Registration District No. 2178

Local Registrar's No. 449

FULL NAME OF CHILD not named - Not viable

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>5-1-</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	--------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>1</u>	
FATHER		MOTHER	
FULL NAME <u>Orin H. Walters</u>	FULL MAIDEN NAME <u>Larsia Jensen</u>		
RESIDENCE <u>Salem</u>	RESIDENCE <u>Salem</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at Salem on the date above stated. 4:45 P. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Louis J. Rich

(Physician or midwife)

Give names added from a supplemental report.

Address Richburg Ida.
Filed 5/30 1923
Registrar.

2

FEB 24 1969

CERTIFICATE OF DEATH

42055

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No.

Registered No. *103*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH **RECEIVED**
County of *Madison* 1923
City of *Salmon* **BUREAU OF VITAL STATISTICS**
If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH. *May 2* 1923
(Month) (Day) (Year)

7. AGE Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1923

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5-2- 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
5-2- 1923 to *5-2-* 1923

that I last saw him alive on *5-2-* 1923

and that death occurred on the date stated above, at *5 P.M.*

The CAUSE OF DEATH was as follows:

*Pneumonia with
not viable*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

2. 1923 (Address)

State the Disease Causing Death; or in death from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

20. UNDERTAKER

DATE OF BURIAL

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

819-129.034-855
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Minidoka RECEIVED
City of Arden MAY 12 1923
No. 1 St. 1 BUREAU OF VITAL
Registration District No. 17 State File No. 111756
Hospital St. Albans Primary Registration District No. 10.15 Local Registrar's No. 56
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth 4/29/1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 11 Number of child of this mother now living, including present birth 11

FATHER
FULL NAME Joe B. Harrison
RESIDENCE Arden
COLOR White AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Utah
OCCUPATION Printer

MOTHER
FULL MAIDEN NAME Ella Henderson
RESIDENCE Arden
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Arden on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. P. Harrison
(Physician or midwife)

Give names added from a supplemental report.
....., 192.....

Address Arden
Filed May 3 1923 E. P. Harrison Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

DECLASSIFIED BY: 6032

63711

No. _____
 Primary Registration District No. _____
 Local Registration No. _____

LEFT SIDE OF CARD

(Certificate of no value without this stamp - 21-1117)

[illegible]

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

Number 1 child of this mother now living, including present birth

NAME	FATHER	NAME	MOTHER
RESIDENCE		RESIDENCE	
COLOR		COLOR	
AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY	
BIRTHPLACE		BIRTHPLACE	
OCCUPATION		OCCUPATION	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life at birth.

Report International to most books same as

505

RECEIVED

MAY 12 1923 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42056
Registered No. 15

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Minidoka
City of Acquia

BUREAU OF VITAL STATISTICS
Registration District No. 19

Primary Registration District No. 2015

(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Harrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

April 29 1923
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Joseph B. Harrison

11. BIRTHPLACE OF FATHER

(State or Country) ?

12. MAIDEN NAME OF MOTHER

Ella Henderson

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jos. B. Harrison
Acquia, Idaho

15.

Filed May 5 1923

E. Delmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 29 19 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 29 19 23, to April 29 19 23
that I last saw him at home
and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Acquia

4-30-1923

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

689-216-035-263
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. B. No. 11-C-22m-2-2-27

S

County of *Nye*

MAY 12 1923

City of *Princeton*

BUREAU OF VITAL STATISTICS

96

File No. *111759*

No. St.

Primary Registration District No. *1009*

Registered No. *60-A*

Hospital *Yes*

FULL NAME OF CHILD *Ray J. White*

Sex of Child <i>Female</i>	Twin Triplet or other? <i>No</i>	and { Number in order of birth <i>1</i> }	Legitimate? <i>Yes</i>	Date of Birth <i>Apr 16</i>
(To be answered only in event of plural births)				(Month) (Day) (Year) <i>1923</i>

FULL NAME <i>Ray J. White</i>	FATHER <i>Ray J. White</i>
RESIDENCE <i>Princeton Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>34</i> (Years)
BIRTHPLACE <i>Cincinnati Ohio</i>	
OCCUPATION <i>Real Estate</i>	

FULL MAIDEN NAME <i>Mildred O. Rothwell</i>	MOTHER <i>Mildred O. Rothwell</i>
RESIDENCE <i>Princeton Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>37</i> (Years)
BIRTHPLACE <i>Cour de Blane Ida</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth *1* Number of children of this mother now living, including present birth *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *still born* at *1* P.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *M. A. House*

Given names added from a supplemental report.

(Physician or midwife)

Address *Princeton Idaho*

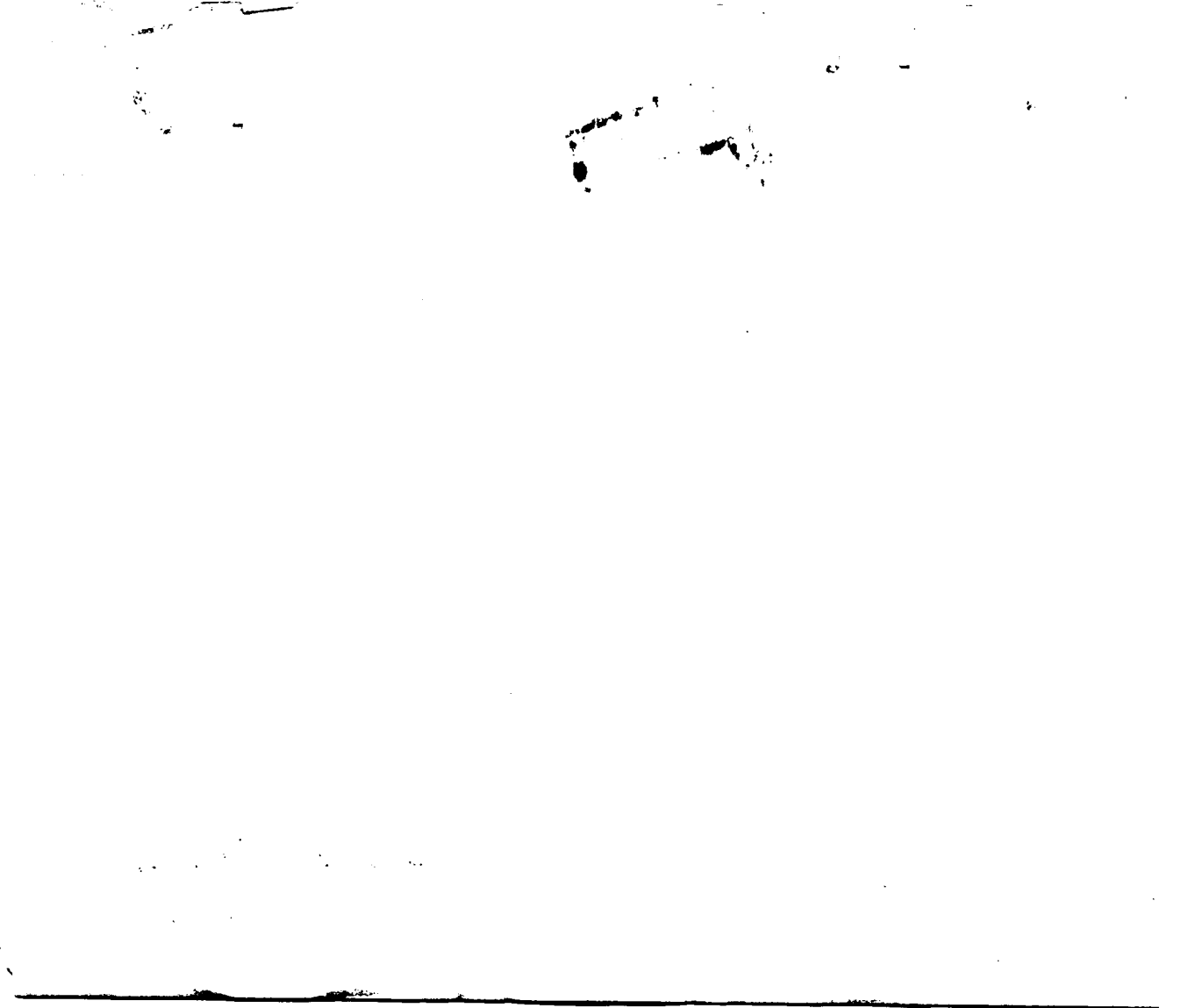
Address *Princeton Idaho*

Filed *5/1/23*

Filed *5/1/23*

Registrar

Registrar



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of BoiseRegistration District No. _____
Primary Registration District No. 1009
(No. _____ St.)File No. 12862
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillman White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

FemaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Apr. 17th 1923
(Month) (Day) (Year)

7. AGE

Stillman
Yrs. _____ Mos. _____ ds. _____IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ray J. White

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mildred Ballard

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ray J. White
South 1st St. Boise

15. Filed

5/23William A. Hahel
Local Registrar

16. DATE OF DEATH

April 17th 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr 17th 1923, to Apr 17th 1923that I last saw h. alive on Apr 17th 1923
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

This baby was still born at 8 months do not know cause of death
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. P. Phumae M. D.19 _____ (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho 4/17/23

20. UNDERTAKER

ADDRESS

Lewiston Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH **STATE OF IDAHO**
 864-217-238-893 **RECEIVED DEPARTMENT OF PUBLIC WELFARE**
BUREAU OF VITAL STATISTICS
 County of Payette **MAY 14** **CERTIFICATE OF BIRTH** **S 111785**
 City of Payette **BUREAU OF VITAL STATISTICS**
 No. 929 3rd Ave. So. St. Registration District No. 4 File No. _____
 Primary Registration District No. 1008 Registered No. 37
 Hospital _____
 FULL NAME OF CHILD Unnamed

Sex of Child Female {Twin Triplet or other? } and {Number in order of birth } Legitimate? Yes Date of Birth Apr. 17 1923
 (To be answered only in event of plural births) (Month) (Day) (Year)

FATHER		MOTHER	
FULL NAME	<u>Eddie C. Young</u>	FULL MAIDEN NAME	<u>Blanche May Hill</u>
RESIDENCE	<u>Payette Idaho</u>	RESIDENCE	<u>Payette Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>28</u> (Years)	AGE AT LAST BIRTHDAY	<u>24</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Machinist</u>	OCCUPATION	<u>Housewife</u>

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:45 A M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____

(Physician or midwife)

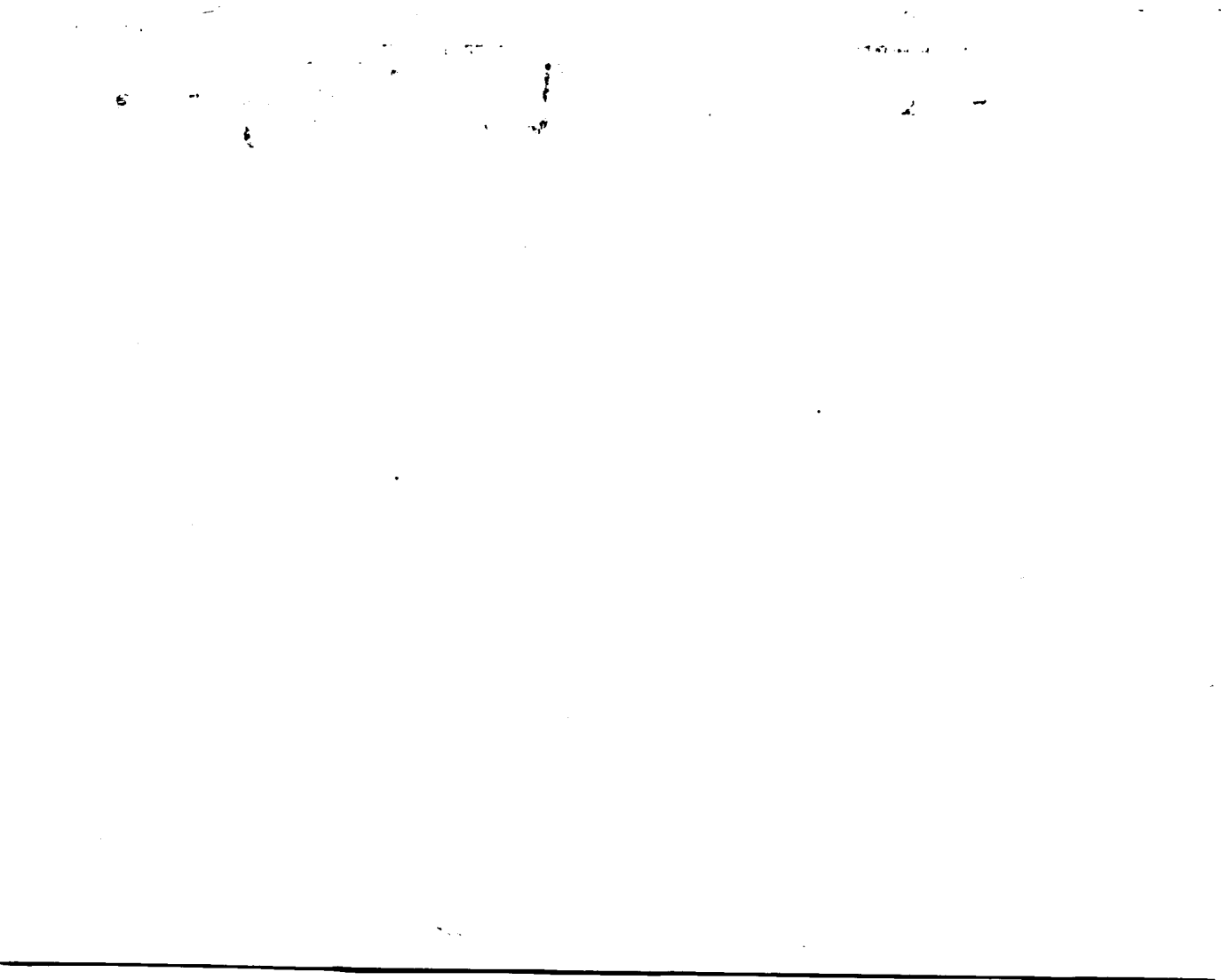
Given names added from a supplemental report. _____

Address _____

Filed _____

Registrar. _____

Registrar. _____



1. PLACE OF DEATH

County of *Payette*
City of *Payette*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

April 17 1923
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Payette Idaho*

10. NAME OF FATHER

Eddie C Young

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Blanche May Hill

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Aug. E. Young*(Address) *Payette Ida*

15.

Filed *April 18 1923* *J. C. Woodward*
Local Registrar

RECEIVED

MAY 11 1923

CERTIFICATE OF DEATH

BUREAU OF VITAL STATISTICS

Registration District No.

Registration District No. *4008*

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *42075*Registered No. *7*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 17 1923 to *Apr. 17 1923*

that I last saw him alive on 19 ..

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth

.....

.....

.....

..... (Duration) Yrs. mos. ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *O. H. Avery* M. D.*4/17/1923* (Address) *Payette, Ida*

.....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

.....

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

.....

.....

19. PLACE OF BURIAL OR REMOVAL

Payette Idaho

20. UNDERTAKER

Glenn C Lander

DATE OF BURIAL

April 17 1923

ADDRESS

Payette Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

753-205-238-467

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH
County of Payette
City of Payette
No. _____ St. _____
Primary Registration District No. 1008 Registered No. 39
FULL NAME OF CHILD Stillborn Child Peterson

RECEIVED

JUN 5 1923

BUREAU OF VITAL
STATISTICSSTATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

111790

File No. _____

Sex of Child female Twin Triplet or other? _____ and _____ Number in order of birth _____ Legitimate? yes Date of Birth May 5 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER
FULL NAME Theodore Peterson
RESIDENCE Payette

COLOR w AGE AT LAST BIRTHDAY 38
(Years)

BIRTHPLACE Kansas

OCCUPATION Labarer

MOTHER
FULL MAIDEN NAME Edith Magnuson
RESIDENCE Payette

COLOR w AGE AT LAST BIRTHDAY 37
(Years)

BIRTHPLACE Sweden

OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 4a M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G. C. Paxton M.D.

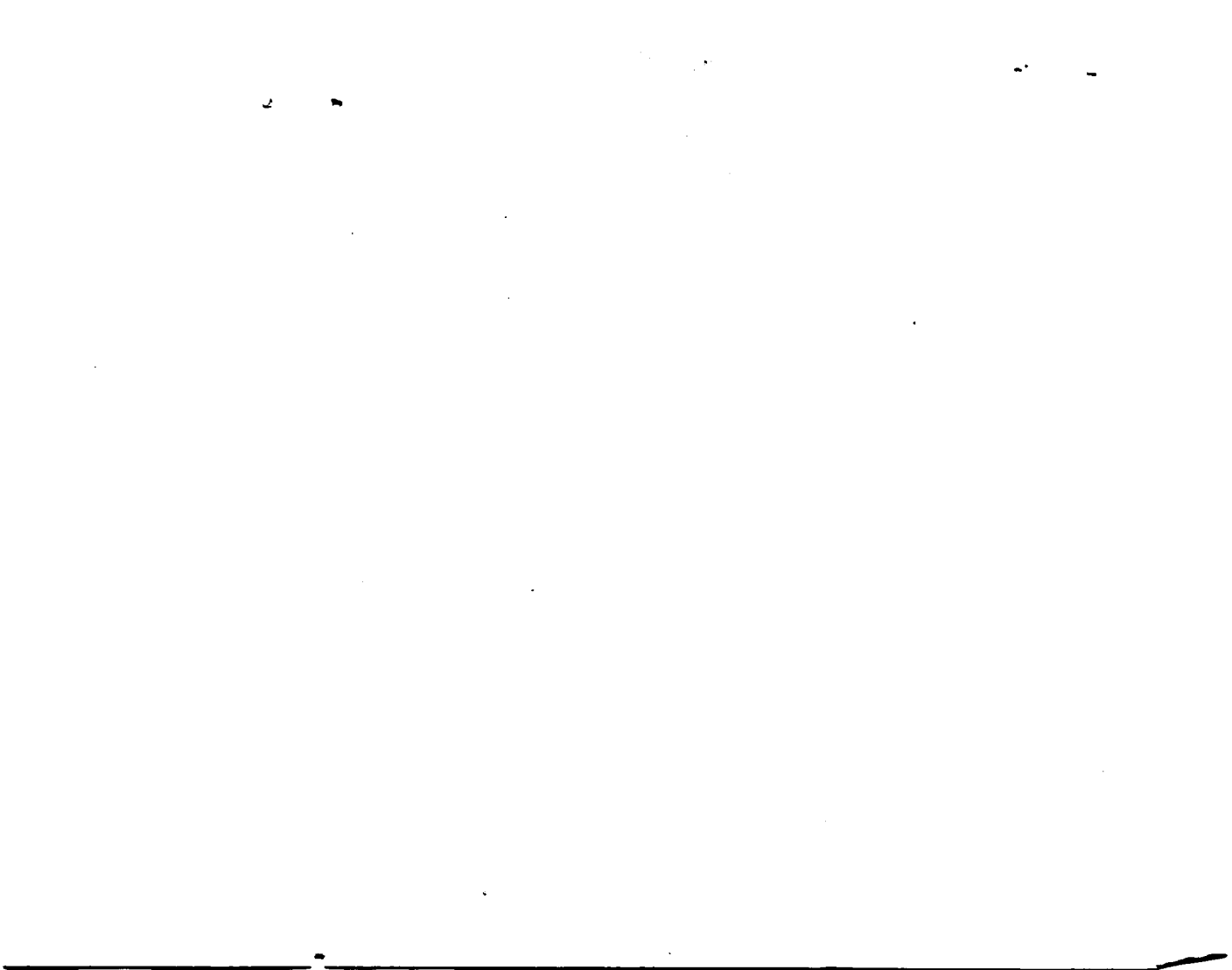
(Physician or midwife)

Given names added from a supplemental report.

19

Address Fruitland, IdaFiled May 6 1923 J. C. Woodward
Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH..... District No. 4
County of Payette Primary Registration District No. 1008
City of Payette (City or Town) St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Stillborn Infant Peterson

File No. 42073
Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE no 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)6. DATE OF BIRTH May 5 - 1923
(Month) (Day) (Year)7. AGE Still born IF LESS than 1 day how many hrs. or mins.?8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9. BIRTHPLACE Payette
(State or Country)10. NAME OF FATHER Theodore Peterson11. BIRTHPLACE OF FATHER Kansas
(State or Country)12. MAIDEN NAME OF MOTHER Edith Magnuson13. BIRTHPLACE OF MOTHER Sweden
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theodor Peterson
(Address) Payette Idaho.15. Filed May 5/1923 191 J. O. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 - 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 191 to 191,
that I last saw h. Still born in pawn alive on 191,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:Still born
(Duration) yrs. mos. ds.Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) P. G. Tanton M. D.
19 (Address) Forville and Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Id DATE OF BURIAL May 5/1923
20. UNDERTAKER Theodore Peterson ADDRESS Payette Id

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

815-2191042-363
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

111841

County of Living Falls

City of Living Falls

No. _____ St. _____

Registration District No. 37

File No. 111841

Hospital _____

Primary Registration District No. 2085

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>5</u> <u>19</u> <u>1923</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FULL NAME <u>FATHER</u> <u>Walter Haulon</u>	RESIDENCE <u>Living Falls Ida.</u>	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	BIRTHPLACE <u>Colorado</u>	OCCUPATION <u>Farming</u>
---	------------------------------------	--------------------	---	----------------------------	---------------------------

FULL MAIDEN NAME <u>MOTHER</u> <u>Doc Collins</u>	RESIDENCE <u>Living Falls Ida.</u>	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	BIRTHPLACE <u>Nebraska</u>	OCCUPATION <u>Housekeeping</u>
--	------------------------------------	--------------------	---	----------------------------	--------------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 12 30 9 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. D. Fisher
Physician
(Physician or midwife)

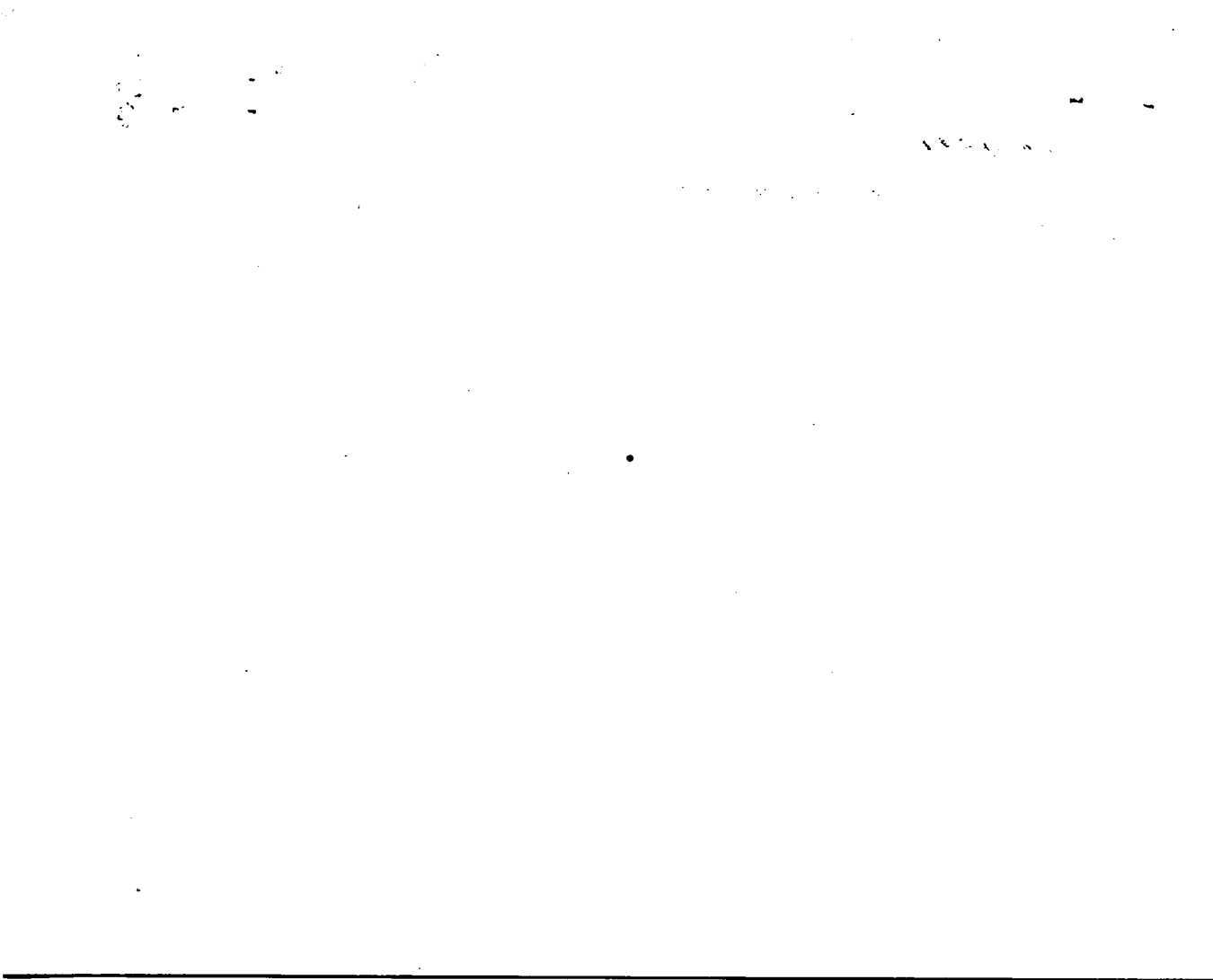
Give names added from a supplemental report.

Address Living Falls Ida.

Filed June 1 - 1923 John F. Coughlin

Registrar.

Registrar.



*This Baby was still-born
we never named her.*

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Mrs. Walter

Boise, Idaho 6/9 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place (CITY _____
of (ST. _____
Birth (COUNTY _____
FATHER _____

FILE NO. 111841
DATE OF BIRTH _____
SEX OF CHILD Female
MOTHER _____
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Signature of Father or Mother

and

Hanson.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

County of

Primary Registration District No. 2085

City of

(No. R. F. D.

St.)

File No.

12123

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Hanlon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 1 19123

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary & intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

364206-0432
PLACE OF BIRTH

RECEIVED
MAY 13 1923
BUREAU OF VITAL STATISTICS
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

111896

County of Valley
City of Cascade
No. _____ St. _____
Hospital _____ Primary Registration District No. _____ Registered No. _____
FULL NAME OF CHILD Stillbirth
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>-</u>	and	Number in order of birth <u>-</u>	Legiti- mate? <u>yes</u>	Date of birth <u>April 6</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 3 ... Number of child of this mother now living, including present birth... 2 ...

FATHER		MOTHER	
FULL NAME	<u>Roy Combo</u>	FULL MAIDEN NAME	<u>Verna Lillian McKie</u>
RESIDENCE	<u>Smith's Ferry, Idaho.</u>	RESIDENCE	<u>Smith's Ferry, Idaho</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>41</u> (Years)	AGE AT LAST BIRTHDAY	<u>35</u> (Years)
BIRTHPLACE	<u>Missouri</u>	BIRTHPLACE	<u>Missouri</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 8 a. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. F. Rutledge
(Physician or midwife)

Give names added from a supplemental report.

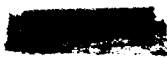
Address Cascade Idaho

Filed 5-3- 1923 Stillb Case

Registrar.

Registrar.

8



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Valley
City of Cascade

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

StillbirthRECEIVED
MAY 1923
BUREAU OF VITAL STATISTICS
STATE OF IDAHO
CERTIFICATE OF DEATH
Registration District No. 15
Primary Registration District No. _____
St. _____State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 42131

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

April 6 1923
(Month) (Day) (Year)

7. AGE

(in utero)
8 Mos. 15 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Cascade Idaho

10. NAME OF FATHER

Ray Combs

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Verna Lillian McKie

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. F. Rutledge M.D.

(Address)

Cascade Idaho

15.

Filed

19Stella Cain
Duffy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 6 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased on April 6 1923 to April 6 1923 that I last saw her alive stillborn 7/8 1923 and that death occurred on the date stated above, at 8 a. M. The CAUSE OF DEATH* was as follows:Unknown

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. F. Rutledge M. D.4/13 1923 (Address) Cascade Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

355-108-001-799
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JUN 5 1923
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

27.

S

County of Ada
City of Meridian
No. _____ St. _____
Hospital _____ Primary Registration District No. _____ Registered No. _____
File No. 111964
FULL NAME OF CHILD Summers Frankie Lee
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth (Month) <u>6</u> (Day) <u>8</u> (Year) <u>1923</u>
What bactericidal solution was used in eyes? <u>1% sol Silver Nitrate</u>					
Number of child of this mother, including present birth. <u>3</u>			Number of child of this mother now living, including present birth. <u>2</u>		
FATHER FULL NAME <u>H. Troy Summers</u>			MOTHER FULL MAIDEN NAME <u>Gella May Price</u>		
RESIDENCE <u>Meridian Idaho</u>			RESIDENCE <u>Meridian I.</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)		COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)	
BIRTHPLACE <u>Ark.</u>			BIRTHPLACE <u>Oklahoma</u>		
OCCUPATION <u>farmer</u>			OCCUPATION <u>housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 3:30 a M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

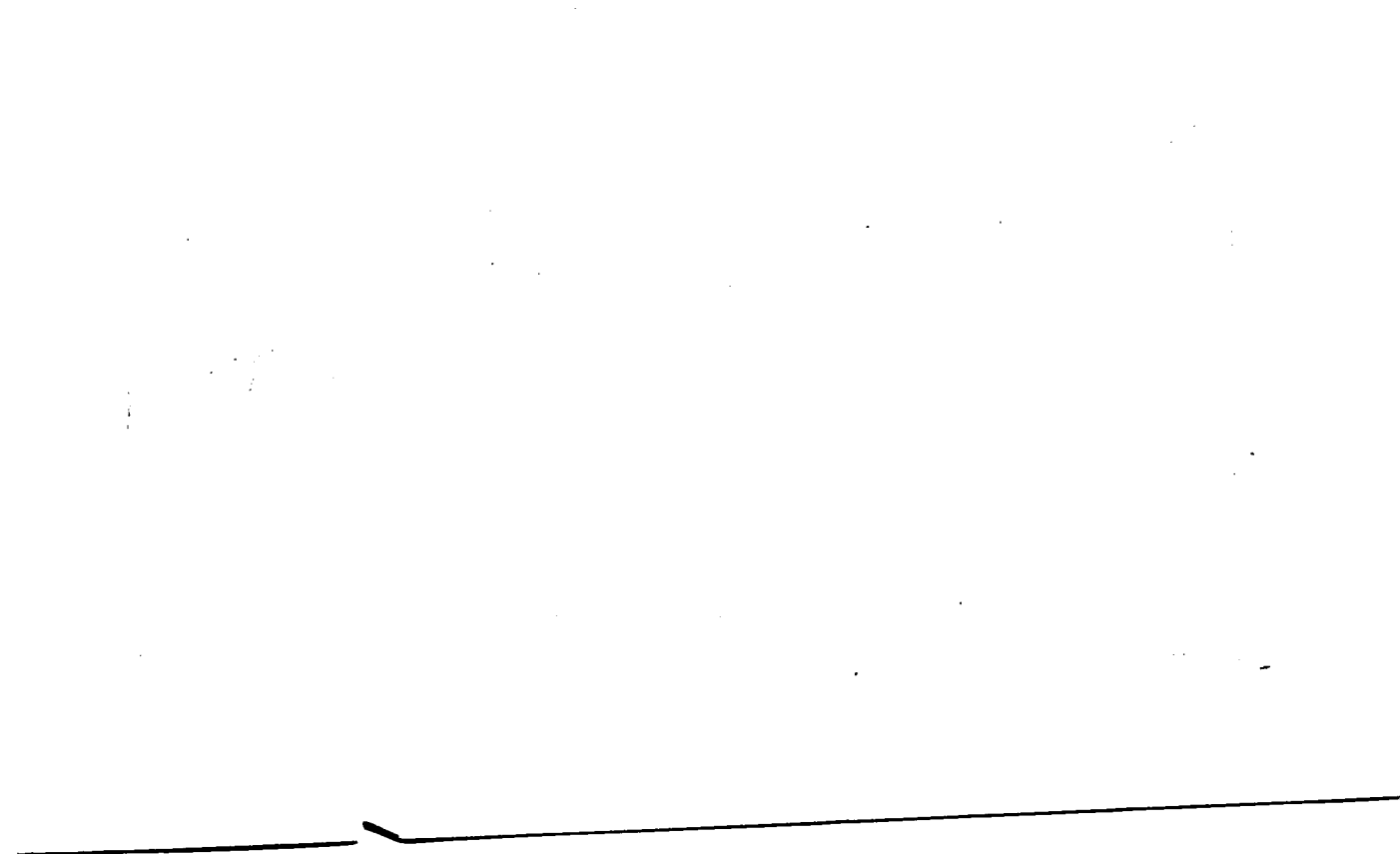
(Signature) H. F. Neal
M. D.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Meridian Idaho
Filed 6-1 1923 H. F. Neal
Registrar.

1011 1012 1013 1014 1015



FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(No. St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 5-9 1923

Local Registrar

CERTIFICATE OF DEATH

BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

42184

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Neal M. D.

5-8 1923 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery 5/9 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. R.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

269-2191003-453 PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock RECEIVED

City of Graino, Idaho JUN 7 1914

CERTIFICATE OF BIRTH

No. R. F. H. St. Registration District No. 83 State File No. 112012

Hospital..... Primary Registration District No. 2160 Local Registrar's No.....

FULL NAME OF CHILD.....
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin <u>Twins</u> or other (To be answered only in event of plural births)	and { Number in order of birth <u>2d</u> }	Legitimate? <u>Yes</u>	Date of birth <u>May - 19 -</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	--	--	------------------------	--

What bactericidal solution was used in eyes? none
Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME W. H. Lorensen
RESIDENCE Graino, Idaho R. F. H.
COLOR W AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Sweden
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Jessie Melstrom
RESIDENCE Graino, Idaho
COLOR W AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 9:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. J. Hestergren
Physician
(Physician or midwife)

Give names added from a supplemental report. Address Graino, Idaho

Filed 5-10-1923 Registrar H. J. Hestergren

Registrar.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 83
City of Armo-Ida Primary Registration District No. 2160
(No. of St.)File No. 42216

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME None

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

May - 19 - 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?
Yrs. _____ Mos. _____ ds. _____

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Armo Ida R. 7th

10. NAME OF FATHER

W. H. Lowman

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Genevieve Meldrum

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Lowman(Address) Armo Ida R. 7th

15.

Filed May - 20 - 1923Local Registrar B. H. Briggs

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May - 19 - 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May - 19 - 1923 to _____ 19____that I last saw him alive on _____ 19____
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia palleata(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) Right max. perforation(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) B. H. Briggs M. D.5 - 20 - 23 (Address) Armo Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Armo, Ida 5 - 21 - 1923

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

194-102-203-251

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock JUN 7 1923

City of Robur BUREAU OF VITAL

CERTIFICATE OF BIRTH

No. St. STATISTICS

Registration District No. 83

State File No. 112015

Hospital..... Primary Registration District No. 2160

Local Registrar's No.

FULL NAME OF CHILD.....

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>no</u>	and { Number in order of birth of birth }	Legitimate? <u>yes</u>	Date of birth <u>June 7 - 1923</u> (Month) (Day) (Year)
--------------------------	----------------------------------	---	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth. 4

Number of child of this mother now living, including present birth. 3

FATHER
FULL NAME Joseph Armstrong,
RESIDENCE Robur, Ida.
COLOR W AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Virginia
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Mary Beale
RESIDENCE Robur, Idaho
COLOR W AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Pennsylvania
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:00 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]
Physician or midwife

Address Lawrence, Idaho

Filed 6-3-1923

Registrar.

Registrar.

2

THE

THE

THE

THE

THE

THE

THE

THE

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY _____	FILE NO. <u>112015</u>
	(ST. _____	DATE OF BIRTH _____
	(COUNTY _____	SEX OF CHILD <u>Male</u>
	FATHER _____	MOTHER <u>Mary Beale</u> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

RECEIVED This child was born dead and was it n
JUL 30 1923

BEAU OF VITAL
STATISTICS

Mrs Joseph Armstrong
Signature of Father or Mother

10-10-10 10-10-10 10-10-10
10-10-10

T

awed.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

253-2481-203-231 PLACE OF BIRTH

County of Bannock
City of Pocatello

No. 28 St. 89

Hospital General

FULL NAME OF CHILD Rose Stillborn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JUN 25 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
112061

Primary Registration District No. 1161 State File No. 4984
Local Registrar's No. 4984

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>No</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>May 28, 1923</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth <u>4</u>		Number of child of this mother now living, including present birth <u>2</u>	
FATHER FULL NAME <u>Norman C. Beckley</u>	MOTHER FULL MAIDEN NAME <u>Minnie Blair</u>	FATHER RESIDENCE <u>628 W. Sherman Pocatello</u>	MOTHER RESIDENCE <u>Pocatello Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Michigan</u>	OCCUPATION <u>R.R. Brakeman</u>	BIRTHPLACE <u>Longmont Colo</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 530 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. N. Hadden
Physician
(Physician or midwife)

Give names added from a supplemental report. 1923
Address 312 Carlson Bldg Pocatello
Filed 4/1 1923
Regist. W. H. Hadden Registrar

UNION OF THE UNITED STATES OF AMERICA
 IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the State of Idaho at Boise, Idaho, this 1st day of January, 1917.

PLACE OF BIRTH

STATE OF IDAHO
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

115061

Registration No. _____
 Local Registration No. _____
 State File No. _____

FULL NAME OF CHILD

Sex of Child _____
 (To be marked only in case of physical defect)
 Type of defect _____
 and in order of birth _____
 Number _____
 Date of birth _____
 (Month) (Day) (Year)

What pathological condition was used in case?

FATHER		MOTHER	
NAME	RESIDENCE	NAME	RESIDENCE
_____	_____	_____	_____
AGE AT LAST BIRTHDAY _____	AGE AT LAST BIRTHDAY _____	AGE AT LAST BIRTHDAY _____	AGE AT LAST BIRTHDAY _____
BIRTHPLACE _____	BIRTHPLACE _____	BIRTHPLACE _____	BIRTHPLACE _____
OCCUPATION _____	OCCUPATION _____	OCCUPATION _____	OCCUPATION _____
COLOR _____	COLOR _____	COLOR _____	COLOR _____

Number of child of this mother, including present birth _____
 Number of child of this father, including present birth _____
 Number of child of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 born at _____
 on the date above stated.

(When there was no attending physician or midwife, then the father, mother, or other person should make the return. A signature which is one that neither the father nor mother or other person of the child makes.)

(When there was no attending physician or midwife, then the father, mother, or other person should make the return. A signature which is one that neither the father nor mother or other person of the child makes.)

(Give names added from a supplemental report)

Signature _____
 Date _____
 Registrar

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

42241

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence,—give facts called for under special information.

2. FULL NAME

JUN 25 1923

Registration District No. *28*

BUREAU OF VITAL STATISTICS

Registration District No. *216*(No. *General Hospital* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *59*Registered No. *4085*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

May 28 1923
(Month) (Day) (Year)

7. AGE

*Stillborn*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF FATHER

N. C. Buckley

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Minnie Mand Blair

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. C. Buckley

(Address)

628 - West Sherman

15.

Filed

*5/29 1923**J. P. Young*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 28 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*May 28 1923, to May 28 1923.*that I last saw him alive on *Stillborn* 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. N. Maddam M. D.
5/29 1923 (Address) *Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain View Cem**May 30 1923*

20. UNDERTAKER

ADDRESS

*Schumacher & Hall**Pocatello*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

356-218.00 K-713
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

S

JUN 25 1923

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH

112142

County of Bear Lake
City of Paris

No. _____ St. _____

Registration District No. 53

File No. 160

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input type="checkbox"/>	and {	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>May 18</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 3 Number of children of this mother now living, including present birth... 2

FATHER
FULL NAME Elzo Wayne Lewis
RESIDENCE Paris Idaho
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Idaho
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Louise Amy Palmer
RESIDENCE Paris Idaho
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... still born premature at... 9:45 P.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

about 8 mos baby.
(Signature) C.O. Moore M.D.
(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed 5-31 1923 Mrs. J. S. Skinner

Registrar.

Registrar.

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

100

100

100

100

100

100

100

100

100

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Paris FILE NO. 112142
 (ST. _____ DATE OF BIRTH _____
 (COUNTY Beauregard SEX OF CHILD Female
 FATHER Edgar W. Lewis MOTHER Lucina A. Palmer
 (Maiden Name)

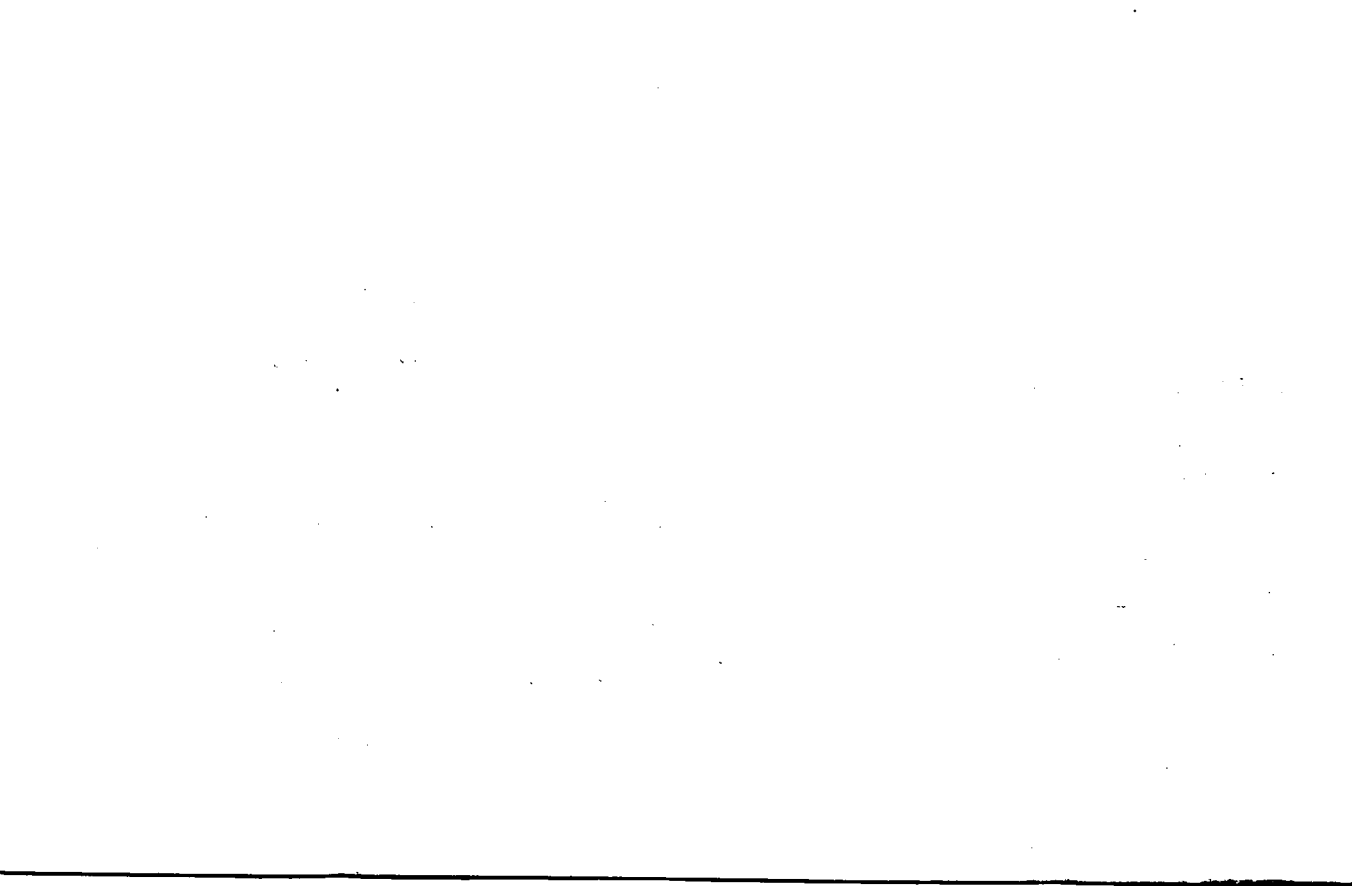
I HEREBY CERTIFY that the child herein described has been named:

No name, still born baby

RECEIVED
 JUL 28 1923
 BUREAU OF VITAL
 STATISTICS

Edgar W. Lewis

Signature of Father or Mother.



CERTIFICATE OF DEATH

42245

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake Registration District No. 6-8
City of Paris No. 1923 St.)File No. 46

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.BUREAU OF VITAL
STATISTICS

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single

(Write the word.)

6. DATE OF BIRTH.

May
(Month)18
(Day)1923
(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country) Bear Lake10. NAME OF
FATHERElroy Wayne Lewis11. BIRTHPLACE
OF FATHER(State or Country) Bear Lake12. MAIDEN NAME
OF MOTHERLeona Amy Palmer13. BIRTHPLACE
OF MOTHER(State or Country) Bear Lake

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elroy Wayne Lewis

(Address)

Paris Idaho

15.

Filed May 21 1923Mrs. J. S. Skinner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May
(Month)18
(Day)1923
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born baby
Premature

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. O. Moore

M. D.

5/20/1923 (Address) Paris Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris Idaho5-21-1923

20. UNDERTAKER

ADDRESS

Harold L. PriceParis Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. R.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

693-110-006-753
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Goshute

No. 121

Hospital St. Stephens

FULL NAME OF CHILD Samuel Wilcox

(Certificate of no value without full name of child.)

Sex of Child male Twin Triplet or other? no and Number in order of birth 1 Legitimate? yes Date of birth June 10, 1923
(Month) (Day) (Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER	MOTHER
FULL NAME <u>Samuel Orin Wilcox</u>	FULL MAIDEN NAME <u>Sarah Peterson</u>
RESIDENCE <u>Goshute Ida</u>	RESIDENCE <u>Goshute Ida</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>50</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Cedar Fork Utah</u>	BIRTHPLACE <u>Frankville Utah</u>
OCCUPATION <u>farmer</u>	OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) D. J. Robert
Physician
(Physician or midwife)

Address Goshute Ida
Filed July 5 1923 D. M. Thaler
Registrar.

Registrar.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **42667**
Registered No. **111**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **111**
County of **Bingham** Primary Registration District No. **111**
City of **Shelley** BUREAU OF VITAL STATISTICS St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Samuel Wilcox**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Infant**
(Write the word.)
6. DATE OF BIRTH **June 10 1923**
(Month) (Day) (Year)
7. AGE **Stillborn** IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Shelley Ida

10. NAME OF FATHER

Samuel Orris Wilcox

11. BIRTHPLACE OF FATHER

(State or Country)

Cedar Fork Utah

12. MAIDEN NAME OF MOTHER

Sarah Petersen

13. BIRTHPLACE OF MOTHER

(State or Country)

Brantsville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J.P. Robert
Shelley Ida.

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 10 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 10 1923** to **June 10 1923**
that I last saw him alive on **Stillborn** 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn
(7 months.)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J.P. Robert

M. D.

1923

(Address)

Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

599-218'039-213

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. E. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

JUN 25 1923

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

S 112255

County of PomerCity of Amer. FallsRegistration District No. 25File No. 11

No. _____ St.

Hospital BethanyPrimary Registration District No. 2072Registered No. 527

FULL NAME OF CHILD

Ellen Genevieve EricksonSex of
Child FemaleTwin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth
(To be answered only in event of plural births)Legiti
mate? YesDate of
BirthMay 18 1923
(Month) (Day) (Year)FULL
NAMEFATHER
Carl Erickson

RESIDENCE

Amer. Falls

COLOR

whiteAGE AT LAST
BIRTHDAY27
(Years)

BIRTHPLACE

Sweden

OCCUPATION

millnerFULL
MAIDEN
NAMEMOTHER
Edna Dalholm

RESIDENCE

Sumner

COLOR

whiteAGE AT LAST
BIRTHDAY39
(Years)

BIRTHPLACE

S. Nebr

OCCUPATION

HousewifeNumber of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Shel born, at S. P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

C. J. Schiefel

(Physician or midwife)

Given names added from a supplemental report.

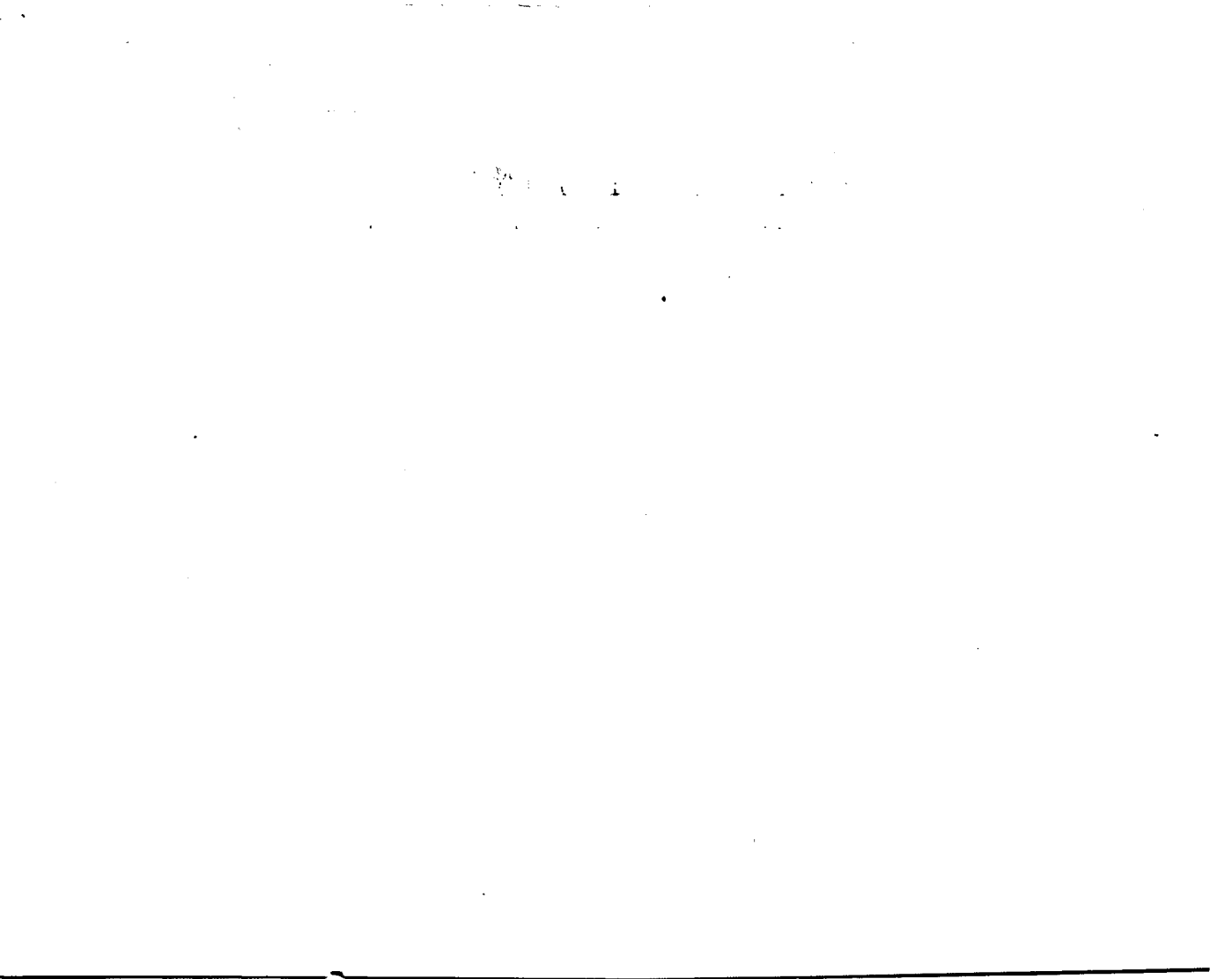
19

Address

Filed June 20 1923

Registrar

Genevieve North
H. J. Fitzpatrick
Registrar



STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY American Falls FILE NO. 112255
 (ST. Third DATE OF BIRTH May 18 - 1923
 (COUNTY Powell SEX OF CHILD Female
 FATHER Carl August Erickson MOTHER Ellen Salholm
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Ellen Genevieve Erickson

Carl A Erickson

Signature of Father or Mother.

10. 10. 10. 10. 10. 10.

10. 10. 10. 10. 10. 10.

10. 10. 10. 10. 10. 10.

10. 10. 10. 10. 10. 10.

10. 10. 10. 10. 10. 10.

10. 10. 10. 10. 10. 10.

10. 10. 10. 10. 10. 10.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

266-230-~~AP~~-153
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville

City of Mylo

No. home

Hospital home

RECEIVED
JUN 9 1923

Registration District No. 73

BUREAU OF VITAL STATISTICS
Primary Registration District No. 215-0

CERTIFICATE OF BIRTH

File No. 112264

Registered No. 274

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>and</u> { Number in order of birth <u>1</u> } (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>4/30</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9 Number of children of this mother now living, including present birth 4

FATHER
FULL NAME William Bowles
RESIDENCE Regley no 1
COLOR White AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Nephi Utah
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Elizabeth Peterson
RESIDENCE Regley no 1
COLOR White AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Medford creek ut
OCCUPATION home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. G. E. Hall MD

(Physician or midwife) Regley

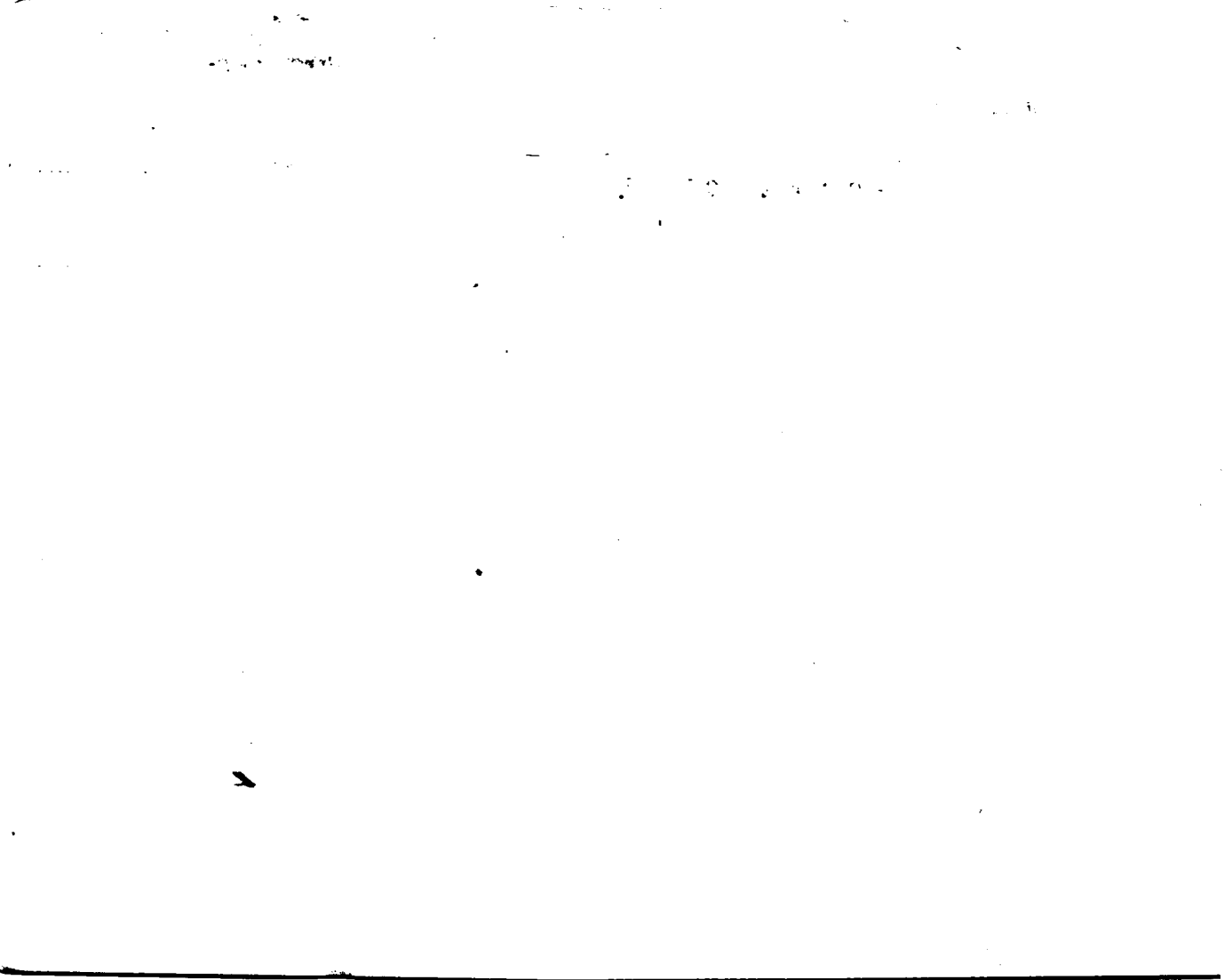
Give names added from a supplemental report.

Address

Filed 6/11 1923

Registrar.

Registrar.



DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY FILE NO. 112264
 (ST. Idaho DATE OF BIRTH April 21, 1923
 (COUNTY Bonanza SEX OF CHILD Female
 FATHER W. L. L. MOTHER Elizabeth A. Peterson
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

No Name Had when Born.William L. L.

Signature of Father or Mother.

VED
1923
VITAL
STATISTICS

859-208'010-389

PLACE OF BIRTH

RECEIVED

JUN 25 1923

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

County of BonnevilleCity of Idaho FallsBUREAU OF VITAL
STATISTICSRegistration District No. 73

File No. _____

No. Bld & Cedar St.Primary Registration District No. 2140 Registered No. 223Hospital Spencer

FULL NAME OF CHILD _____

Sex of
Child FemaleTwin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birthLegiti
mate? yesDate of
Birth May 8

(Month) (Day)

1923
(Year)FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY 26

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY 21

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at _____ M.
on the date above stated. (Born alive or stillborn)(Signature) H. D. Spencer

(Physician or midwife)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

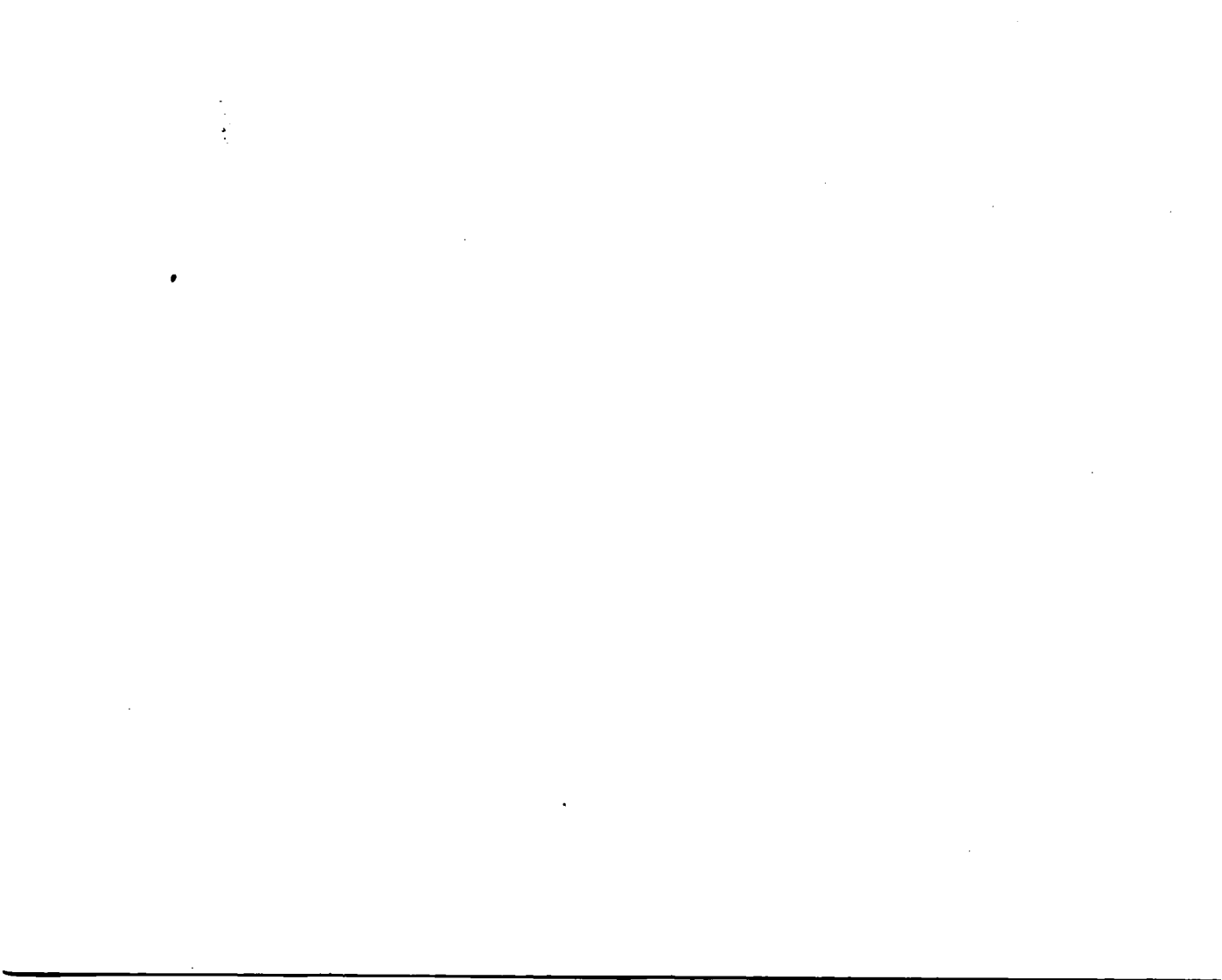
Given names added from a supplemental report.

19

Address Idaho Falls IdahoFiled May 24 19 23

Registrar

Registrar



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

County of Boundary

City of Bonner Ferry

Registration District No. 79

File No. 112324

No. _____ St. _____

Hospital Bonner Ferry Primary Registration District No. 2156

Registered No. _____

FULL NAME OF CHILD

Helen Louise Simonds

Sex of Child Female Twin Triplet Quin and Number in order of birth 2 Legit mate? Yes Date of Birth June 7th 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME Clinton D. Simonds FATHER
RESIDENCE Bonner Ferry
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE S. Dak.
OCCUPATION _____

FULL MAIDEN NAME Inga Dew MOTHER
RESIDENCE Bonner Ferry
COLOR white AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE N. Dak.
OCCUPATION Housewife

~~WHAT MATERNAL SOLUTION WAS USED IN CASE OF 1% 1920/3~~

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ on the date above stated.

Stillborn at 7.30 A.M.
(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]
Physician
(Physician or midwife)

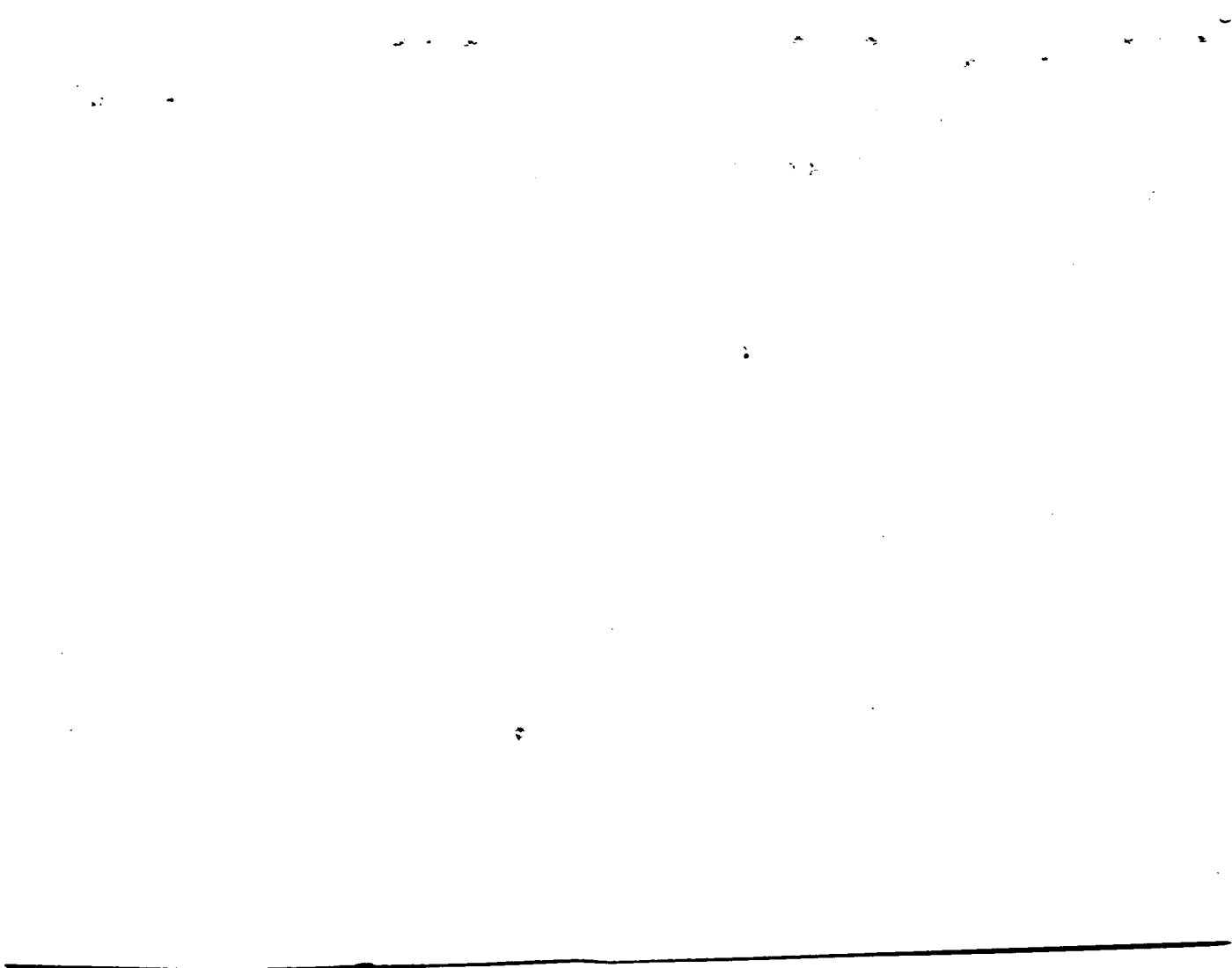
Given names added from a supplemental report.

Address Bonner Ferry, Ida.

Filed 6/29/23

Registrar

Registrar



STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY <u>Bonners Ferry</u>	FILE NO. <u>112334</u>
	(ST. <u>Idaho</u>	DATE OF BIRTH <u>June 7-1923</u>
	(COUNTY <u>Boundary</u>	SEX OF CHILD <u>Female</u>
	FATHER <u>Clinton D. Simonds</u>	MOTHER <u>Louisa Jew Simonds</u> (Maiden Name)

RECEIVED

BUREAU OF VITAL
STATISTICS

I HEREBY CERTIFY that the child herein described has been named:

Helen Louise Simonds

C. D. Simonds

Signature of Father or Mother

me

023

sd

er

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Duration)

(Signed)

1923

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

791-127.009-293
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner
City of Sandpoint

JUN 9 1923
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

112353

No. _____ St. _____ Registration District No. 78 File No. _____
Hospital City Primary Registration District No. 2155 Registered No. _____
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u> { and } Number in order of birth <u> </u>	Legiti-mate? <u>yes</u>	Date of birth <u>June 27 1923</u> (Month) (Day) (Year)
--------------------------	---	-------------------------	---

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth..... Number of child of this mother now living, including present birth.....

FATHER		MOTHER	
FULL NAME <u>James L. Graham</u>	FULL MAIDEN NAME <u>Leona May Kitchen</u>		
RESIDENCE <u>409 7th St. Sandpoint</u>	RESIDENCE <u>409 7th St. Sandpoint</u>		
COLOR <u>White</u>	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>20</u>	AGE AT LAST BIRTHDAY <u>20</u>
BIRTHPLACE <u>California</u>	BIRTHPLACE <u>Sandpoint, Ida.</u>		
OCCUPATION <u>Lumberpiler</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at 7:45 A. M. on the date above stated.
(born or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Floyd C. Wendle
M. D.
(Physician or midwife)

Give names added from a supplemental report.

Address Sandpoint, Ida.
Filed July 2 1923 Viola Allen
Deputy Registrar.

Registrar.

10

11

12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **42290**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonner Registration District No. 78
City of Sandpoint Registration District No. 2155 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 27, 1923
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James Graham

11. BIRTHPLACE OF FATHER

(State or Country)

California

12. MAIDEN NAME OF MOTHER

Lena May Kitchen

13. BIRTHPLACE OF MOTHER

(State or Country)

Sandpoint, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Graham

(Address)

Sandpoint, Ida

15.

Filed June 27, 1923Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 27, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...

that I last saw him alive on 19...

and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH* was as follows:

Stillborn PrematureDoubly Lobar Pneumonia in mother

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

By [Signature]Address Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. / days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

At home

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laborer Cemetery6/27, 1923

20. UNDERTAKER

ADDRESS

L. J. Moore Sandpoint Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

345-111-2212 PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED
JUN 9 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County *Franklin*
City of *Preston*
No. St.
Hospital

Registration District No. *27* State File No. *112576*
Primary Registration, District No. *2119* Local Registrar's No. *152*

FULL NAME OF CHILD *Stillborn*
(Certificate of no value without full name of child.)

Sex of Child <i>Male</i>	Twin Triplet or other? <i></i>	and Number in order of birth <i></i>	Legitimate? <i>yes</i>	Date of birth <i>6 11 1923</i> (Month) (Day) (Year)
--------------------------	--------------------------------	--------------------------------------	------------------------	--

What bactericidal solution was used in eyes? *Ag. 287*

Number of child of this mother, including present birth <i>9</i>		Number of child of this mother now living, including present birth <i>7</i>	
FATHER FULL NAME <i>Charles E. Lund</i>	MOTHER FULL MAIDEN NAME <i>Margarette Baker</i>		
RESIDENCE <i>Preston, Ida.</i>	RESIDENCE <i>Preston, Ida.</i>		
COLOR <i>W</i>	AGE AT LAST BIRTHDAY <i>47</i> (Years)	COLOR <i>W</i>	AGE AT LAST BIRTHDAY <i>38</i> (Years)
BIRTHPLACE <i>Idaho Utah</i>	BIRTHPLACE <i>Idaho</i>		
OCCUPATION <i>Farming</i>	OCCUPATION <i>Housewife</i>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* at *6 15* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *A. R. Cutler*
Physician (Physician or midwife)

Give names added from a supplemental report.
....., 192.....
Registrar.

Address *Preston, Idaho*
Filed *July 3 1923* *Myrolda Lippert*
Registrar.

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-11-2001 BY 60322 UCBAW

...TO THE ...

1. The first part of the document is a letter from the President of the United States to the President of the Senate, dated January 1, 1901. The letter is signed by William McKinley and is addressed to Charles McNary. The letter is a copy of a letter that was sent to the President of the Senate by the President of the United States.

1944-1945

[illegible][illegible]

DEATH-TRIP

[illegible]

1. I have been in the United States since 1954. I am a native-born American citizen. I have been married to my wife, [redacted], since 1954. We have two children, [redacted] and [redacted]. I am currently employed as a [redacted] at [redacted]. I have no other sources of income. I have no criminal record. I have no outstanding debts. I have no other information to report.

[illegible]

10-10-68

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

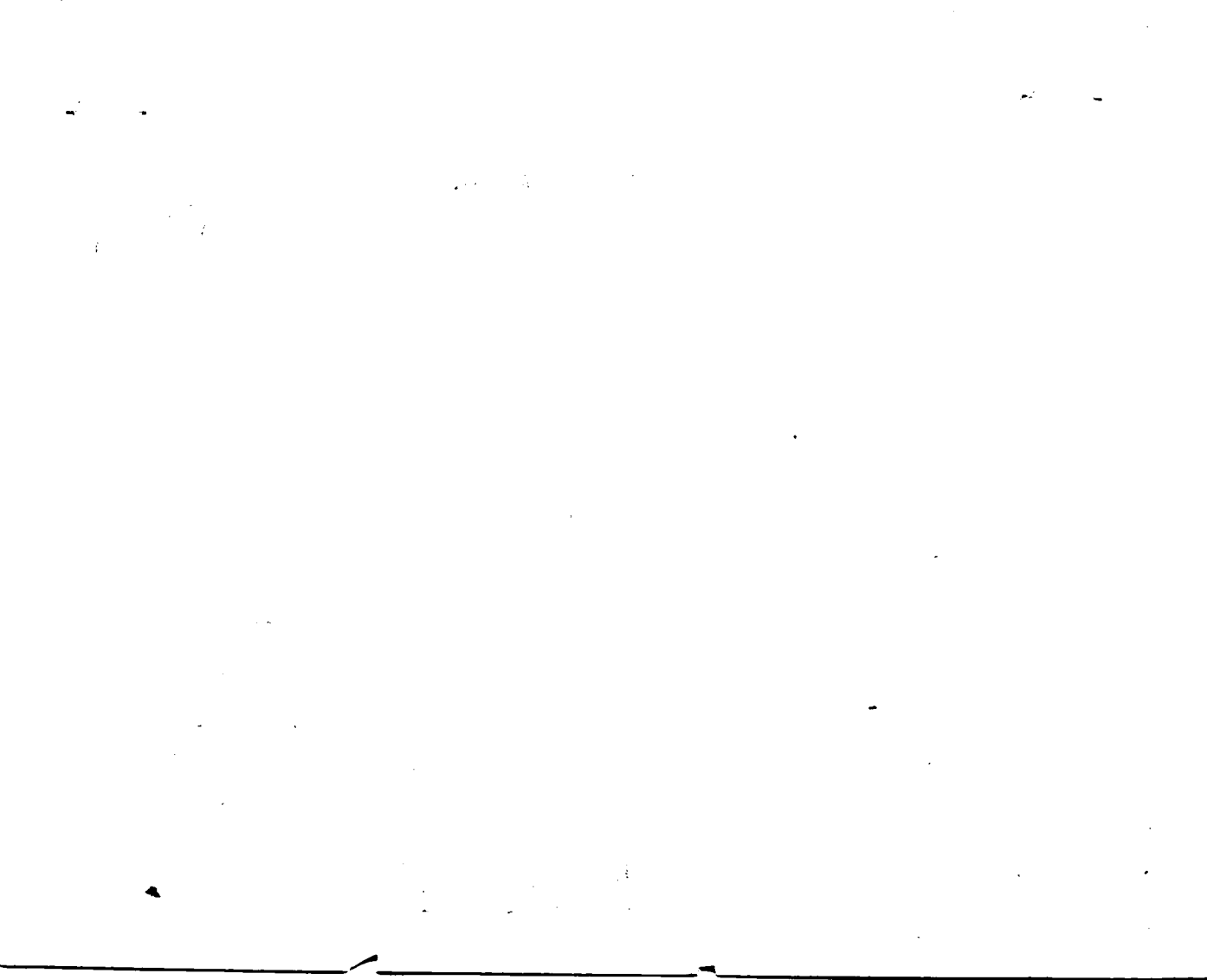
BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY <u>Preston</u>	FILE NO. <u>112576</u>
	(ST. _____	DATE OF BIRTH <u>June 11 1923</u>
	(COUNTY <u>Franklin</u>	SEX OF CHILD <u>Male</u>
	FATHER <u>Charley Lund</u>	MOTHER <u>Maggie Baker</u> (Maiden Name)

RECEIVED
JUL 23 1923
BUREAU OF VITAL
STATISTICS

I HEREBY CERTIFY that the child herein described has been named:
Child was dead born. And no name given
Margaret L. Lund
 Signature of Father or Mother.



RECEIVED
JUN 5 1923
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **42380**
Registered No. **37**

1. PLACE OF DEATH

County of *Franklin*
City of *Preston*

Registration District No. *27*
Registration District No. *2119*
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

June 11 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Charles E. Lund

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Margarette Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Father

(Address)

15.

Filed *July 3 1923*

Mrs. Ida Lippich
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 11 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 4 1923 to June 4 1923
that I last saw her *still born* alive on *June 4 1923*

and that death occurred on the date stated above, at *4:15 P.M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

A. R. Queller M. D.

4/12 1923 (Address) *Preston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston Idaho

DATE OF BURIAL

6-11 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

666-212-221-215
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin

JUN 9 1923

City of Clifton

BUREAU OF VITAL CERTIFICATE OF BIRTH

112588

No. _____ St. _____

STATISTICS

Registration District No. 27

State File No. 2

Hospital _____

Primary Registration District No. 2119

Local Registrar's No. 151

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>June 19</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Marion Howell
RESIDENCE Clifton, Ida.
COLOR W AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Idaho
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Elsie Sant
RESIDENCE Clifton, Ida.
COLOR W AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn 3 26 on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

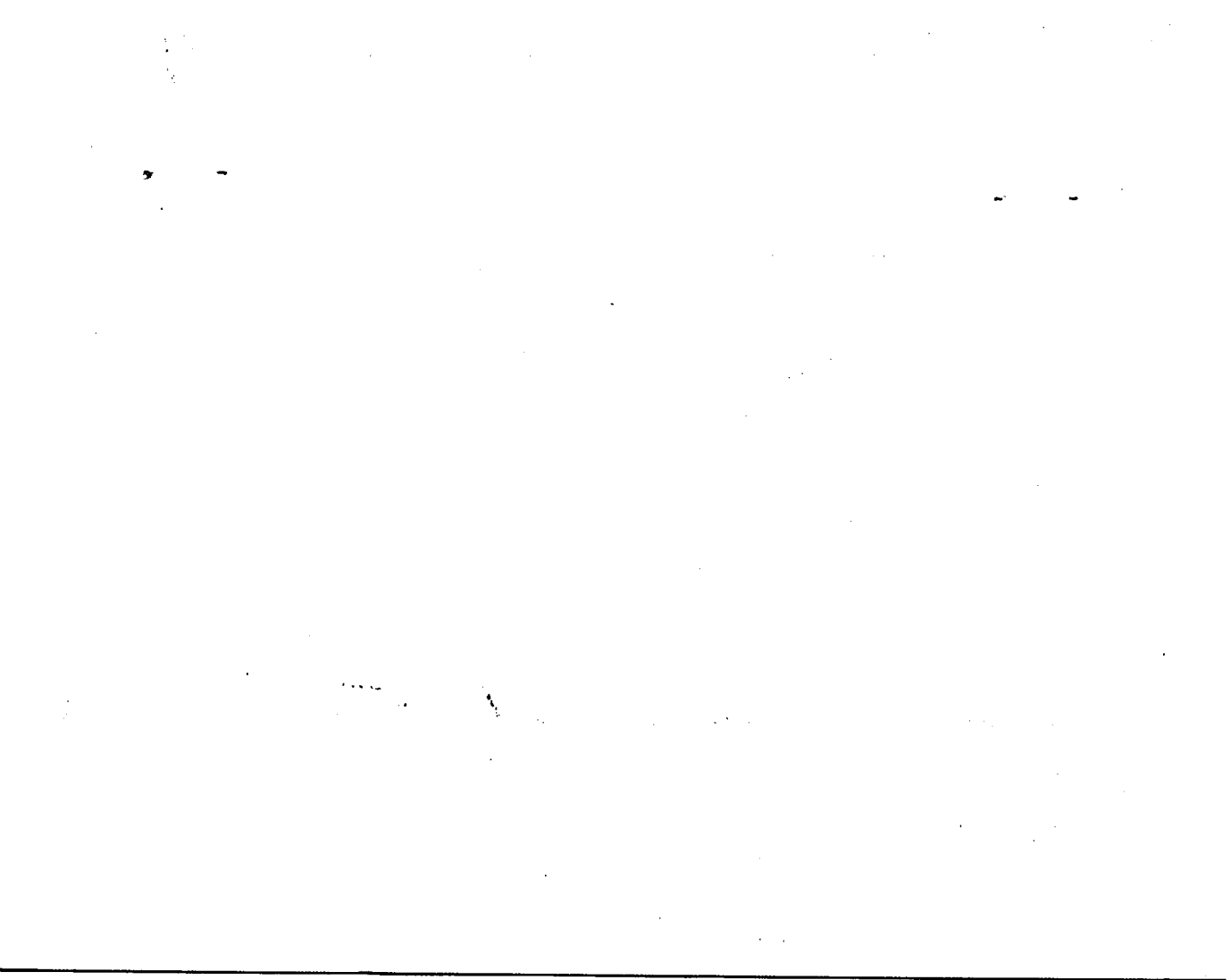
(Signature) A. R. Cullen
Physician
(Physician or midwife)

Address Preston, Idaho

Filed July 3 1923

Mrs. Ida Lyppek
Registrar.

Registrar.



RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **42379**
Registered No. **38**

1. PLACE OF DEATH

County of *Franklin*
City of *Clifton*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

June 19 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Marion Howell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elsie Sant

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Father

(Address)

15.

Filed

July 3 1923

Mrs. Ida Zupp
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 19 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19 1923 to *June 19 1923*
that I last saw her alive on *June 19 1923*

and that death occurred on the date stated above, at *3:30 P.M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

A. R. Quilley M. D.

4-20 1923 (Address) *Preston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clifton Idaho

6-20 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

668-126-023-195
PLACE OF BIRTH

RECEIVED
JUN 5 1923
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Greymont
City of St. Anthony
No. _____ St. Registration District No. 99 State File No. 112605
Hospital _____ Primary Registration District No. 2177 Local Registrar's No. 112
FULL NAME OF CHILD Charles J. Cordyce
(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>No</u>	and {	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 16, 1923</u> (Month) (Day) (Year)
-----------------------	----------------------------------	-------	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>1</u>	
FULL NAME <u>Charles J. Cordyce</u>	FATHER	FULL MAIDEN NAME <u>Jennie Arnold</u>	MOTHER
RESIDENCE <u>St. Anthony, Idaho</u>		RESIDENCE <u>St. Anthony, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Sigmon, Iowa</u>		BIRTHPLACE <u>Dillon, Montana</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>Housewife</u>	

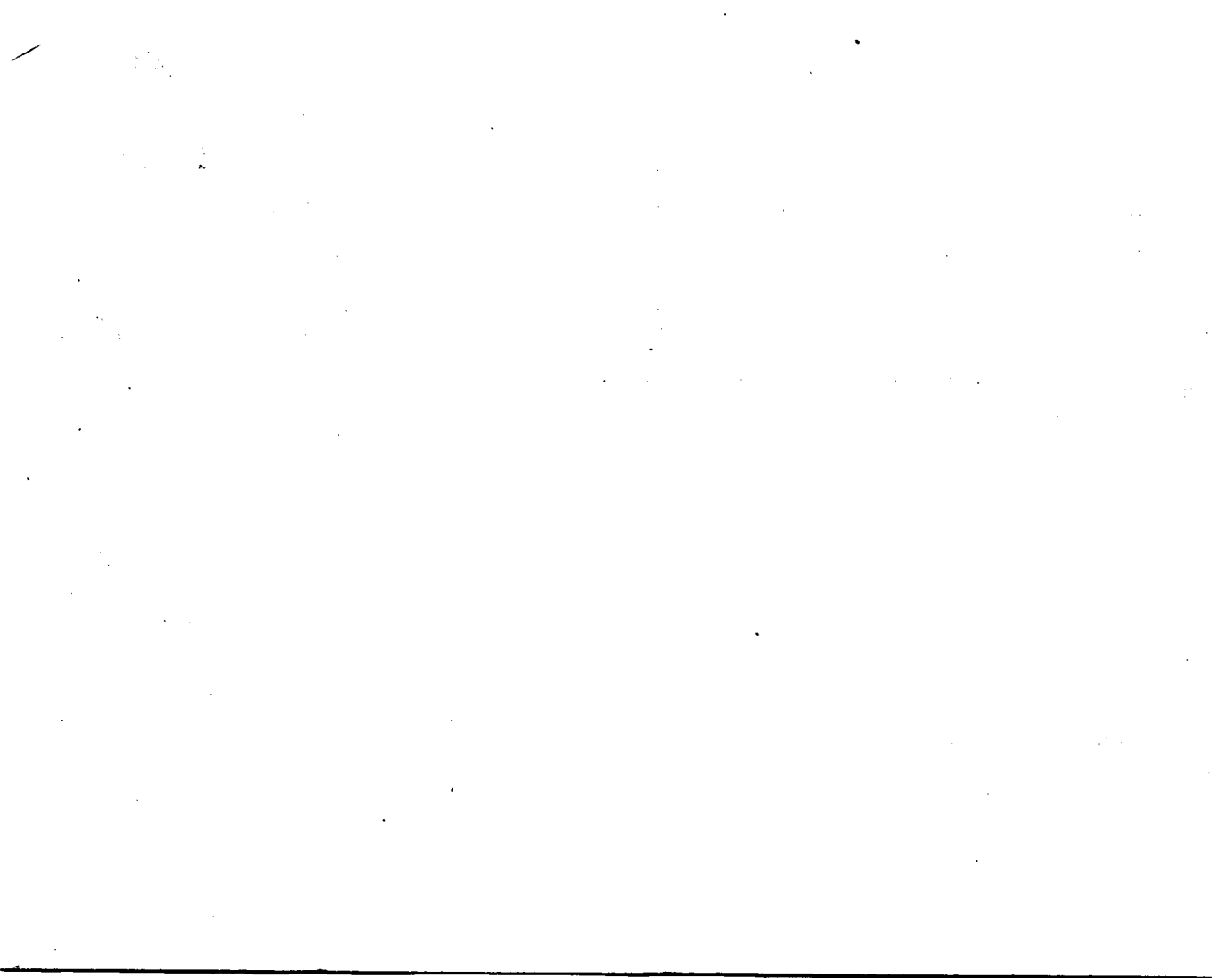
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at St. Anthony on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Jennie A. Searey
(Physician or midwife)

Give names added from a supplemental report.
Address St. Anthony, Idaho
Filed 7/2 1923
Registrar. _____ Registrar.



622-224-24-799

PLACE OF BIRTH

RECEIVED

JUN 2 1923

STATE OF IDAHO

Form V.-B. No. 11-C—Rev. 1-1-18

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

S

County of GoodingCity of HagermanRegistration District No. 21File No. 112655

No. _____ St. _____

Primary Registration District No. _____

Registered No. _____

Hospital _____

FULL NAME OF CHILD

Frieda Louise Osborn

Sex of Child <u>Female</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____ (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of Birth <u>Feb 24</u> 19 <u>23</u> (Month) (Day) (Year)
----------------------------	--	------------------------	--

FULL NAME <u>Freda Osborn</u>	FATHER <u>E. Osborn</u>	FULL MAIDEN NAME <u>Nellie Girsham</u>	MOTHER _____
RESIDENCE <u>Hagerman</u>	RESIDENCE <u>Hagerman</u>	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>4</u> (Years)	BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Mo</u>
BIRTHPLACE <u>Iowa</u>	OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth <u>NO 3</u>	Number of children of this mother now living, including present birth <u>1</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Stillborn at 6 a. m.
(Born alive or stillborn)R. N. Greene
(Physician or midwife)

Given names added from a supplemental report.

Address

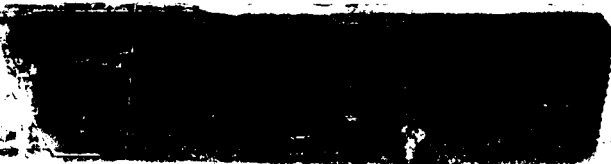
Filed

Mar 5 1923

Registrar

Registrar

2



FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 2 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Gooding District No. 2
City of Hagerman (No. _____) Registration District No. _____ St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Freda Louise Osborn

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42402

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Infant
(Write the word.)

6. DATE OF BIRTH

Feb 24 1923
(Month) (Day) (Year)

7. AGE

Still born IF LESS than 1 day
how many _____ hrs.
or 15 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Hagerman

10. NAME OF FATHER

Chas E Osborn

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Nellie Girsham

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E E Osborn
Hagerman

15. Filed

Mar 5 1923

R N Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Infant
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Still born 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R N Greene M. D.

Mar 5 1923

(Address) Hagerman

*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried

Feb 24 1923

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

331 116-026-695 PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED
JUN 25 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Jefferson
City of Regby
No. 98 St. Jefferson District No. 98 File No. 112724
Hospital 1 Primary Registration District No. 2176 Registered No. 83

FULL NAME OF CHILD _____
(Certificate of no value without full name of child.)

Sex of Child <u>m</u>	Twin Triplet or other? _____ and {Number in order of birth _____}	Legitimate? <u>YES</u>	Date of birth <u>6-16-1923</u> (Month) (Day) (Year)
-----------------------	---	------------------------	--

What bacterioidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>1</u>	Number of children of this mother now living, including present birth <u>0</u>
FULL NAME <u>Orville Clark</u>	FULL MAIDEN NAME <u>Myrtle Finch</u>
RESIDENCE <u>Poplar</u>	RESIDENCE <u>same</u>
COLOR <u>w</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>w</u> AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Utah</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 11 a. M.
on the date above stated. (Born alive or stillborn)

(Signature) Ray H. Fisher
(Physician or midwife)

Give names added from a supplemental report.
_____, 192____
_____, 192____
_____, 192____

Address Regby
Filed 6-16-1923 Ray H. Fisher
Registrar.

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON WAS
 EXAMINED BY THE PHYSICIAN OF THE HOSPITAL AND FOUND
 TO BE IN GOOD HEALTH AND FIT TO RETURN TO HIS
 HOME AND TO HIS USUAL OCCUPATIONS.

FULL NAME OF PATIENT [Illegible]		Hospital [Illegible]	
DATE OF BIRTH [Illegible]		SEX [Illegible]	
OCCUPATION [Illegible]		RESIDENCE [Illegible]	
COLOR [Illegible]		AGE AT LAST [Illegible]	
BIRTHDAY [Illegible]		BIRTHDAY [Illegible]	
OCCUPATION [Illegible]		RESIDENCE [Illegible]	
CERTIFICATE OF ATTENDING PHYSICIAN OF HOSPITAL I hereby certify that I attended the birth of this child, who was born on the date above stated. [Illegible Signature]			

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Payson FILE NO. 112724
 (ST. _____ DATE OF BIRTH 6/16/1923
 (COUNTY Jefferson SEX OF CHILD Male
 FATHER Orville Clark MOTHER Myrtle Finch
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

No Name. Miscarriage 5 1/2 Mo.

Orville Clark

Signature of Father or Mother.

ED
923
VITAL
TICE

12

RECEIVED
JUN 20 1923
STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6-16-23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Ray J. Fisher M. D.

6-16-23 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

SEPARATE RETURN must be made for each child, in order of birth stated.

253-111-000-157

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jefferson

City of Rehby

No. home St. home

Hospital home

RECEIVED

JUN 25 1923

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

98

File No. 112725

Primary Registration District No. 2176

Registered No. 111

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>and</u> { Number in order of birth } Legitimate? <u>Yes</u>	Date of birth <u>3/11</u> 192 <u>3</u> (Month) (Day) (Year)
-----------------------	---	--

What bacteriocidal solution was used in eyes?.....

Number of child of this mother, including present birth... 5 Number of children of this mother now living, including present birth... 4

FULL NAME <u>Peter J. Butts</u>	FATHER
RESIDENCE <u>Rehby Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>45</u> (Years)
BIRTHPLACE <u>Burgman Mt.</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Lucia Rex</u>	MOTHER
RESIDENCE <u>Rehby Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Rehby Ida</u>	
OCCUPATION <u>home</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Station at 10 a M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) St. Seal

(Physician or midwife)

Give names added from a supplemental report.

Address Rehby

Filed 6-10 1923 Ray H. Fisher

Registrar.

Registrar.

[illegible]

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY _____	FILE NO. <u>112725</u>
of (ST. _____	DATE OF BIRTH <u>July 1, 1923</u>
Birth (COUNTY _____	SEX OF CHILD <u>Male</u>
	FATHER _____	MOTHER _____
		(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

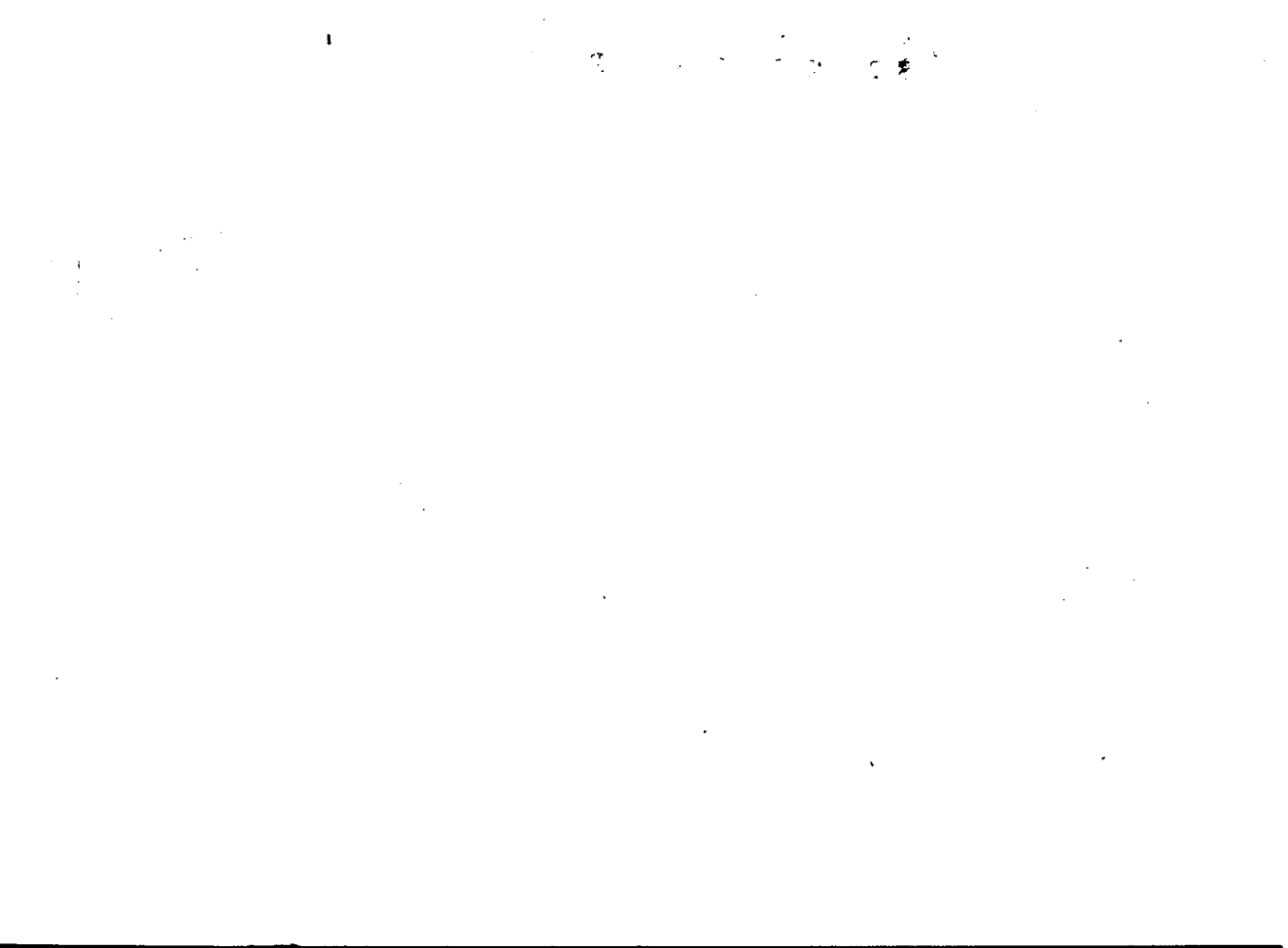
RECEIVED

JUL 24 1923

BEAU OF VITAL

STATISTICS

Miss Betty B. Smith
Signature of Father or Mother.



RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson Registration District No. 98
City of Rexburg Registration District No. 2176 St. _____
BUREAU OF STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 42419Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

3-11-1923
(Month) (Day) (Year)

7. AGE

stillborn IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Peter F Betts

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Julia Fox

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Rexburg Idaho

15.

Filed 6-10-23 19 23

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3-11-23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3-12-23 19 23 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

3-12-23 19 23

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, avoid (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

168-204-026-221

PLACE OF BIRTH

RECEIVED

JUN 25 1923

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Jefferson

City of Hammer

Registration District No. 48

File No. 112738

No. _____ St. _____

Primary Registration District No. 2176

Registered No. 126

Hospital _____

FULL NAME OF CHILD

Baby Johnston

Sex of
Child

7

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti
mate?

yes

Date of
Birth

6-4-23
(Month) (Day) (Year)

FULL
NAME

P. G. Johnston

FATHER

RESIDENCE

Hammer

COLOR

W.

AGE AT LAST
BIRTHDAY

48
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

Charlotte Sparks

MOTHER

RESIDENCE

Hammer

COLOR

W.

AGE AT LAST
BIRTHDAY

43
(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

Number of child of this mother, including present birth 12 Number of children of this mother now living, including present birth 10

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Stillborn at 6 P. M.
(Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Edwin Cutler

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Shelly, Ida

Filed

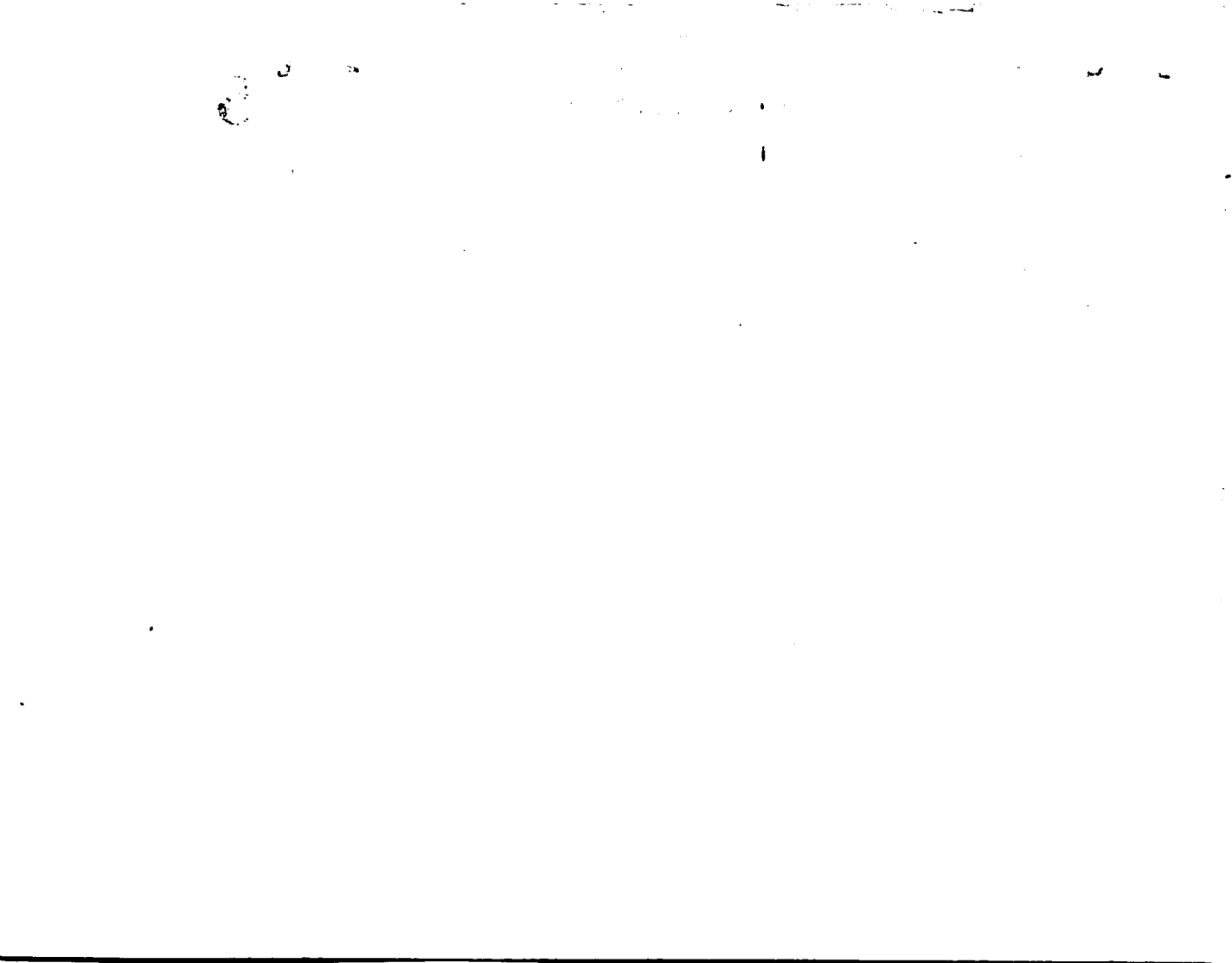
6-10-23

19

Ray Fisher

Registrar

Registrar



FORM V. S. No. 5-25 M. 1/19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

BUREAU OF VITAL STATISTICS

Registration District No.

STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42415

Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

7

white

(Write the word.)

6. DATE OF BIRTH

5 - 4 - 1923
(Month) (Day) (Year)

7. AGE

Still born.

If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Kummer Ida

10. NAME OF FATHER

Geo. P. Johnston

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Charlotte Spink

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edwin A. Adams M.D.

(Address)

Shelley Idaho

15.

Filed

6 - 10

19

23

Ray H. Fisher

Local Registrar

16. DATE OF DEATH

5 - 4 - 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5 - 4 - 1923 to 5 - 4 - 1923

that I last saw him alive on

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH was as follows:

Difficult - delayed delivery

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Mal - presentation

(Duration) Yrs. mos. ds.

(Signed)

Edwin A. Adams M.D.

5/4 - 1923

(Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. Yrs. mos. days. In the State. Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

954-1091827-893

PLACE OF BIRTH

IAHO
STATISTICS

Form V. S. No. 11-C-25m-1-1-18

County of Jerome

RECEIVED

JUN 24 1923

CERTIFICATE OF BIRTH

City of Eden

BUREAU OF VITAL STATISTICS

S 112781

No. Eden R. D., St.Registration District No. 23

File No.

Hospital ☒Primary Registration District No. 2017

Registered No.

FULL NAME OF CHILD

Remsey.

Sex of Child

MIs the child
a twin?
or other?☒

and

Number
in order
of birth☒Is the child
male?Y

Date of Birth

July 9th1923

(Month) (Day) (Year)

FULL NAME

Ray L. Remsey

FATHER

FULL MAIDEN NAME

MOTHER

Dora Gertrude Hicks

RESIDENCE

Dead- killed Oct 1922. by bullet.

RESIDENCE

Eden R. D.

COLOR

W

AGE AT LAST BIRTHDAY

4 8

(Years)

COLOR

W

AGE AT LAST BIRTHDAY

4 0

(Years)

BIRTHPLACE

Ill.

BIRTHPLACE

West Union West Virginia

OCCUPATION

Farmer

OCCUPATION

House.

Number of child of this mother, including present birth

Three

Number of children of this mother now living, including present birth

Two

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Still Bornat 10:30 A. M.

on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Duncan L. HixsonPhysician

(Physician or midwife)

Given names added from a supplemental report.

Address Twin Falls IdahoFiled June 28 1923 E. D. Piper M.D.

Registrar



FORM V. S. No. 5-A—26 M. 1-19.

RECEIVED
MAY 3 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE ()

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37
City of Eden, Ida. Registration District No. 1085
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby RamseyFile No. 41103
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

Feb 9 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

R. L. Ramsey.

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Viola G. Hicks

13. BIRTHPLACE OF MOTHER

(State or Country)

W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs R. L. Ramsey

(Address)

Edens 2 dphs.

15. Filed

Mar. 11923John F. Conaghan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 9 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1923 to Feb 9 1923
that I last saw him alive on Feb 9 1923
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Born dead.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

James A. Alexander M. D.7/10 1923 (Address) Post Office Box

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida. 2-10-1923

20. UNDERTAKER

ADDRESS

R. J. Grossman Twin Falls, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

962-25-028-345
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
JUN 2 1923
COUNTY OF Neelence
CITY OF Harrison
BUREAU OF VITAL STATISTICS
REGISTRATION DISTRICT NO. 126
FILE NO. 142848

S

No. _____ St. _____
Hospital _____
Primary Registration District No. 2204 Registered No. 43

FULL NAME OF CHILD Will Born

(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? _____ and (Number in order of birth) _____ Legitimate? yes Date of birth 6 25 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

FATHER
FULL NAME Donald D. Roul
RESIDENCE Harrison
COLOR White AGE AT LAST BIRTHDAY 1 5
(Years)
BIRTHPLACE Dayton Wash
OCCUPATION Contractor

MOTHER
FULL MAIDEN NAME Freda G. Cunningham
RESIDENCE Harrison
COLOR White AGE AT LAST BIRTHDAY 1 7
(Years)
BIRTHPLACE Bellevue Wash
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. M. Gentry

(Physician or midwife)

Give names added from a supplemental report.

Address Harrison

Filed 6 30 1923

Registrar.

Registrar.

2

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL RECORDS
CERTIFICATE OF BIRTH

Registration District No. 1212 The No. 1212
County No. 1212 District No. 1212 Registered in 1212

FULL NAME OF CHILD 1212

Sex 1212 Date of Birth 1212

What identification number was used in entry 1212

Number of children born to mother including a twin birth 1212

Full Name of Mother 1212

Residence 1212

Color 1212 Birthplace 1212 Occupation 1212

Signature of Physician or Midwife 1212

Signature of Registrar 1212

Address 1212

STATE OF NEW YORK
COUNTY OF NEW YORK
CITY OF NEW YORK
BUREAU OF VITAL RECORDS
1212

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

42446 ✓

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Notenar*
City of *Harrison*

RECEIVED CERTIFICATE OF DEATH

Registration District No. *126*Primary Registration District No. *2204*

BUREAU OF VITAL STATISTICS

File No. *3*Registered No. *22*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still Born Rose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

June 25 1923
(Month) (Day) (Year)

7. AGE

0 If LESS than 1 day
how many hrs. or
..... Yrs. Mos. min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Harrison Id

10. NAME OF FATHER

Donald D Rose

11. BIRTHPLACE OF FATHER

(State or Country)

Wash.

12. MAIDEN NAME OF MOTHER

Freda Cunningham

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Donald D Rose

(Address)

Harrison Id

15.

Filed

6-26 1923

Local Registrar

16. DATE OF DEATH

June 25 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191....., to 191.....

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. D.*626 1923 (Address) *Harrison Id*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Harrison**6-26 1923*

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

553-220-528-79 RECEIVED
PLACE OF BIRTH

JUN 11 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai BUREAU OF VITAL STATISTICS
City of Coeur d'Alene CERTIFICATE OF BIRTH

No. Kiss Island Bay St. Registration District No. 30 File No. 112881
Hospital no Primary Registration District No. 1051 Registered No. 1579

FULL NAME OF CHILD

Elizabeth Nelson
(Certificate of no value without full name of child.)

Sex of Child <u>fe.</u>	Twin Triplet or other? <u>no</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 20</u> 192 <u>3</u> (Month) (Day) (Year)
-------------------------	----------------------------------	-----	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 1

FATHER
FULL NAME Helmer Nelson
RESIDENCE Coeur d'Alene Ida.
COLOR White AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE N.C., Mo.
OCCUPATION Lumberman

MOTHER
FULL MAIDEN NAME Odette Prinsen
RESIDENCE Coeur d'Alene, Ida.
COLOR White AGE AT LAST BIRTHDAY 17 (Years)
BIRTHPLACE France
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born stillborn at 10³⁰ a M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Torgers
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Coeur d'Alene, Ida.
Filed 7/9 1923 D. P. Prinsen
Registrar.

2

STATE OF

Handwritten signature

CLERK OF THE COURT

Ex. cor. ...

ADON

RECEIVED

FILED

41

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

RECEIVED
JUL 28 1923
BUREAU OF VITAL
STATISTICS

Place of Birth (CITY Loewen D'Alene FILE NO. 112881
ST. Big Lost Island DATE OF BIRTH June 20, 1923
COUNTY Kootenai SEX OF CHILD Female
FATHER Harmer Nelson MOTHER Odetta Persson
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Elizabeth Nelson

H. C. Nelson

Signature of Father or Mother.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JUN 11 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42440
Registered No. 1234

1. PLACE OF DEATH
County of *Boatena* Registration District No. *30*
City of *Coeur d'Alene* Registration District No. *105-1* St. *(No.)*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Not names person*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *fr.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)
6. DATE OF BIRTH *June 20 1923*
(Month) (Day) (Year)
7. AGE *1* Yrs. *1* Mos. *1* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *✓*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Kidd Island Bay.*
(State or Country)

10. NAME OF FATHER *Heimer Nelson*

11. BIRTHPLACE OF FATHER *N.C. Mo.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Odette Trinson*

13. BIRTHPLACE OF MOTHER *France.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(Address) _____

15. *7/9* 19 *23*
Filed *DD Drennen*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 20 1923*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Birth* to *Still Born*
that I last saw him *alive on* *19*
and that death occurred on the date stated above, at *M.*
The CAUSE OF DEATH* was as follows:

Version delivery of large baby in bad position

(Duration) *1* yrs. *1* mos. *1* ds.

Contributory (Secondary) *✓*

(Duration) *1* yrs. *1* mos. *1* ds.

(Signed) *J. H. Sturges* M. D.
6/22/23 (Address) *Coeur d'Alene*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *1* yrs. *1* mos. *1* days. In the State *1* yrs. *1* mos. *1* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL *6/21 1923*

20. UNDERTAKER *W. Cressley* ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

255-203-029-366
PLACE OF BIRTH

RECEIVED
JUN 5

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Troy

No. _____ St. _____

Hospital _____

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 61

File No. 112895

Primary Registration District No. 2141

Registered No. 97

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>F</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June 3</u> 192 <u>3</u> (Month) (Day) (Year)
-----------------------	---	-----------------------------	---

What bacteriocidal solution was used in eyes? no

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 5

FULL NAME <u>Jesse P Benjamin</u>	FATHER	FULL MAIDEN NAME <u>Elsie Cook</u>	MOTHER
RESIDENCE <u>Troy</u>		RESIDENCE <u>Troy</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>41</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Iowa</u>		BIRTHPLACE <u>Nebraska</u>	
OCCUPATION <u>Clerk</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 3:45 A M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) E. Magle
Physician
(Physician or midwife)

Give names added from a supplemental report.

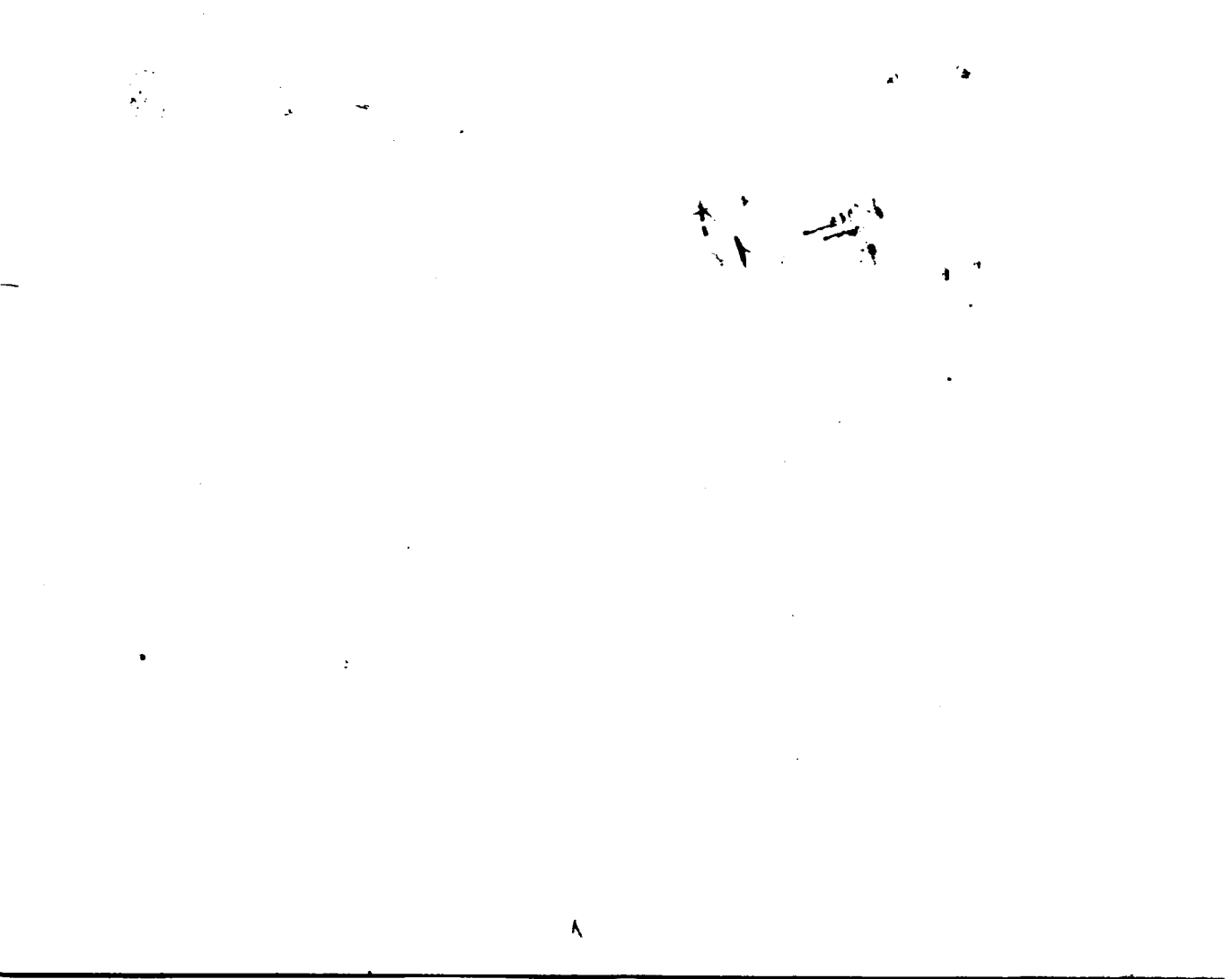
_____, 19____

Registrar.

Address _____

Filed June 5 1923 W. H. Carethers

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 64

County of Latah

City of Troy

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Benjamin

File No. 42465

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 3 1923

(Month)

(Day)

(Year)

7. AGE

0 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Troy Idaho

10. NAME OF FATHER

Jerse P Benjamin

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Elvis J. Beck

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jerse P Benjamin

(Address)

Troy Ida

15.

Filed

June 30 1923 Lucy M. Pickard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

3

1923

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

delivered a Stillborn Child

that I last saw h. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Premature Separation of Placenta
intra uterine death

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

6/3 1923 (Address) W. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burnt Ridge

June 4 1923

20. UNDERTAKER

ADDRESS

none

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever*.—Never report "Typhoid Pneumonia"; *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

299-2061029-214
PLACE OF BIRTH

RECEIVED
JUN 25 1923
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

112935

County of Latah

City of MOSCOW

No. 410 E. B. St. St.

Registration District No. 61

File No.

Hospital

Primary Registration District No. 1011

Registered No. 69

FULL NAME OF CHILD Gwendolyn Louise Kirkham

(Certificate of no value without full name of child.)

Sex of
Child

F

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

May 6

1923

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? Silver Nitrate

Number of child of this mother, including present birth one

Number of child of this mother now living, including present birth none

FULL
NAME

FATHER

Vergil R. Drexel Kirkham

FULL
MAIDEN
NAME

MOTHER

Ruby Adele Bauer

RESIDENCE

MOSCOW

RESIDENCE

MOSCOW

COLOR

W

AGE AT LAST
BIRTHDAY

29

(Years)

COLOR

W

AGE AT LAST
BIRTHDAY

24

(Years)

BIRTHPLACE

Newton, Ill.

BIRTHPLACE

Ritzville, Wash.

OCCUPATION

Geologist

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Harry E. Linhart
Physician
(Physician or midwife)

MOSCOW, Ida.

Give names added from a supplemental report.

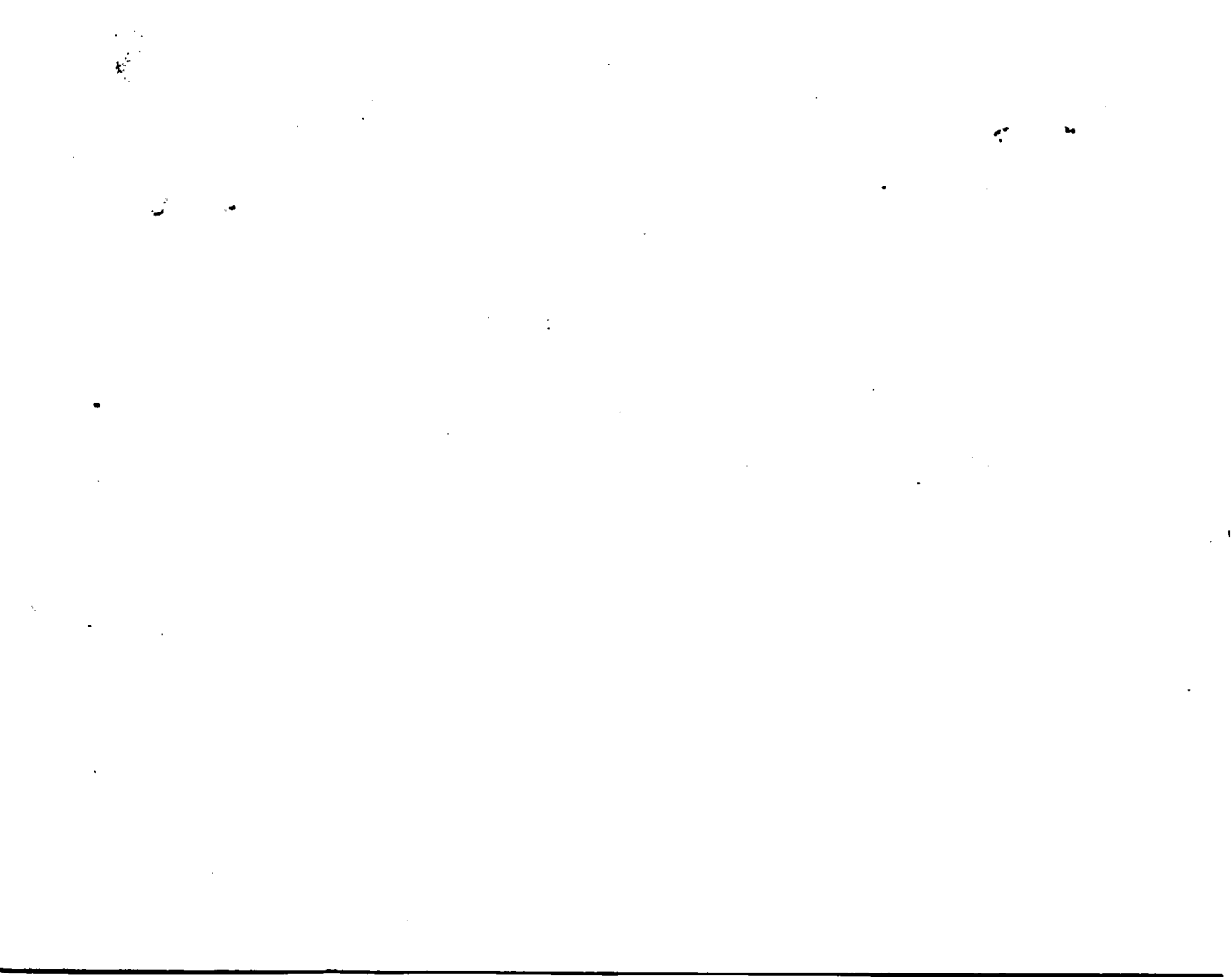
Address

Filed

May 10 1923 M. L. Barithers

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

Form V. S. No. 5 20M.1-16-12

JUN 25 1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH BUREAU OF VITAL STATISTICS Registration District No. 61
County of Talbot Primary Registration District No. 1011
City of Mason (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Quindolyn Louise Kirkham

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42452
Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH May 6 1923
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Virgil R. Quindol Kirkham

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ruby Adelle Bauer

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) V. R. Kirkham

(Address) Mason, Ida.

15.

Filed May 8 1923 W. H. Caruthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 6 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191____, to 191____, that I last saw h_____ alive on 191____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. H. Caruthers M. D.
5/8/23 (Address) Moscow, Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Mason DATE OF BURIAL May 8 1923

20. UNDERTAKER H. R. Short ADDRESS Mason

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

466-2241030-331
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Lemhi
City of Salmon,

No. _____ St. _____

Registration District No. 41

File No. 112992

Hospital _____

Primary Registration District No. 2116

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>6-24-3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Joseph Moodie
RESIDENCE Salmon, Ida.

MOTHER
FULL MAIDEN NAME Vera Clark
RESIDENCE Salmon, Ida.

COLOR white AGE AT LAST BIRTHDAY 39
(Years)

COLOR White AGE AT LAST BIRTHDAY 38
(Years)

BIRTHPLACE Scotland

BIRTHPLACE Moemsur

OCCUPATION Rancher

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) G. P. Brattson, MD.

(Physician or midwife)

Give names added from a supplemental report.

Address Salmon, Idaho

Filed 7/10 1923

Registrar.

Registrar.

2

1911

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH.

RECEIVED

Registration District No.

Primary Registration District No.

BUREAU OF VITAL

STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

1923

M. W. Greene

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Instrumental delivery of
face presentation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

1923 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of MadisonCity of Libbard

JUN 2 1923

CERTIFICATE OF BIRTH

No. 100 St. Registration District No. State File No. 113019Hospital Primary Registration District No. 2178 Local Registrar's No. 466

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of Birth <u>5-15-1923</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 8FATHER
FULL NAME William AddisonRESIDENCE LibbardCOLOR White AGE AT LAST BIRTHDAY 49
(Years)BIRTHPLACE UtahOCCUPATION FarmerMOTHER
FULL MAIDEN NAME Rebekah EdwardRESIDENCE LibbardCOLOR White AGE AT LAST BIRTHDAY 41
(Years)BIRTHPLACE UtahOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at S. P. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Forin St. Rich

(Physician or midwife)

Address Reeburg IdahoFiled 6/10

1923

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

266-206.034689

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Minidoka

JUN 2 1923

CERTIFICATE OF BIRTH

City of Hayden

BUREAU OF VITAL

STATISTIC No.

19

File No.

113045

No. _____ St.

Primary Registration District No. 2015

Registered No. 87

Hospital _____

FULL NAME OF CHILD

Sex of Child <u>Female</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and {	Number in order of birth {	Legiti mate? <u>Yes</u>	Date of Birth <u>May 6</u> 19 <u>23</u> (Month) (Day) (Year)
----------------------------	---	-------	----------------------------	-------------------------	---

FULL NAME <u>Steven W. Bowman</u>	FATHER
RESIDENCE <u>Burley Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Adamsville Utah</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Clarissa White Bowman</u>	MOTHER
RESIDENCE <u>Burley</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Bever Utah</u>	
OCCUPATION <u>Housewife</u>	

WHAT BACTERICIDAL SOLUTION WAS USED IN EVENT

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ on the date above stated.

Stillborn at 6:30 P.M.
(Born alive or stillborn)

{ When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature)

G. H. Cooper
Physician
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Burley, Ida

Filed

June 30 1923

E. O. Edwards

Registrar

Registrar

1

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

86-106-035 - 692 RECEIVED
PLACE OF BIRTH

JUN 9 1923

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

S

County of Blaine

BUREAU OF VITAL

BUREAU OF VITAL STATISTICS

City of Lewiston

STATISTICS CERTIFICATE OF BIRTH

No. _____ St. _____

Registration District No. 96

File No. 113085

Hospital St. Joseph

Primary Registration District No. 1009

Registered No. 88

FULL NAME OF CHILD

Stillborn, Thomas

(Certificate of no value without full name of child.)

Sex of Child male

Twin
Triplet
or other?

and } Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

June 6, 1923
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

Louis Thomas

FULL
MAIDEN
NAME

MOTHER

Mabel E. Fisher

RESIDENCE

Clarkston

RESIDENCE

Same

COLOR

white

AGE AT LAST
BIRTHDAY

50

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

31

(Years)

BIRTHPLACE

New York

BIRTHPLACE

Canada (Toronto)

OCCUPATION

Methodist Minister

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Stillborn, on the date above stated.

5 P. M.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

I. A. H. H. H.

(Physician or midwife)

Give names added from a supplemental report.

Address

Lewiston, Idaho

Filed

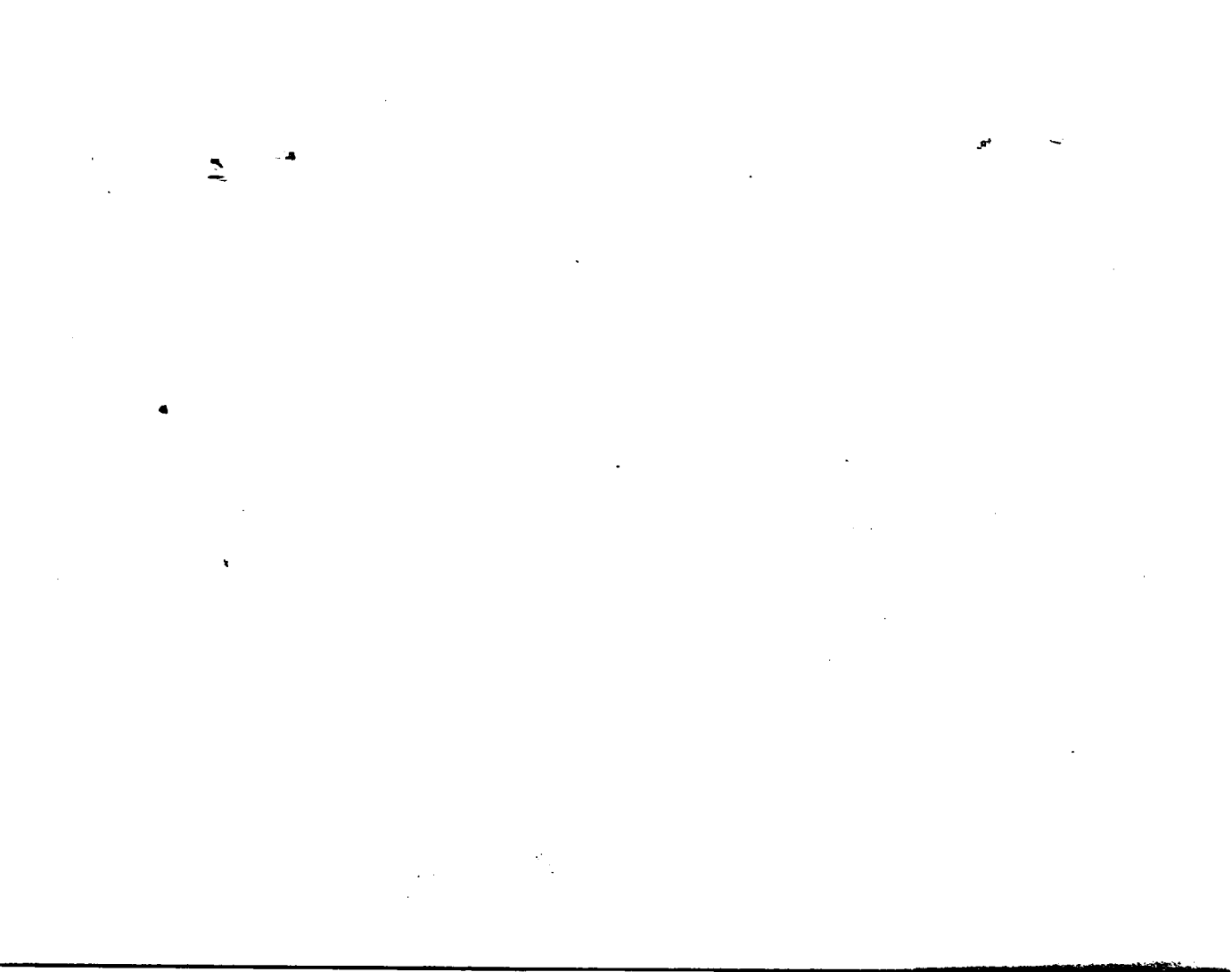
7/1/23

192

Registrar.

Registrar.

Johnson



FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

42512

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bozperce*
City of *Bozperce*JUN 9 1923
BUREAU OF VITAL
STATISTICS

Registration District No.

Primary Registration District No.

(No.)

St.

File No.

Registered No. *86*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis Thomas Jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 6 1923
(Month) (Day) (Year)

7. AGE

*still born*IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Revelston Idaho

10. NAME OF FATHER

Louis Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Mabel E Fisher

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Thomas

(Address)

814 Sycamore St

15.

Filed

7/1/23

19

Nielson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *June 6 1923* to *June 6 1923* that I last saw him alive on *June 6 1923* and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

still birth on account of premature separation of placenta

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Paul W. Thomas M.D.**6/7 1923* (Address) *Revelston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clarkston Wash

DATE OF BURIAL

6/7 1923

20. UNDERTAKER

H. R. Merchant

ADDRESS

Clarkston Wash

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

251-2041-035-683
PLACE OF BIRTH **RECEIVED**
JUN 9 1923
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH
96 113086

County of _____
City of _____
No. _____ St. _____ Registration District No. _____
Hospital _____ Primary Registration District No. 1009
FULL NAME OF CHILD Shelton Bern Registered No. 87
(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? _____ { and } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>June 4</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 1

FATHER	MOTHER
FULL NAME <u>Elton Bern</u>	FULL MAIDEN NAME <u>Bertha Wilson</u>
RESIDENCE <u>Lapras</u>	RESIDENCE <u>Same</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Ida.</u>	BIRTHPLACE <u>Ida.</u>
OCCUPATION <u>farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Shelton at 6 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Shelton Bern

Give names added from a supplemental report.

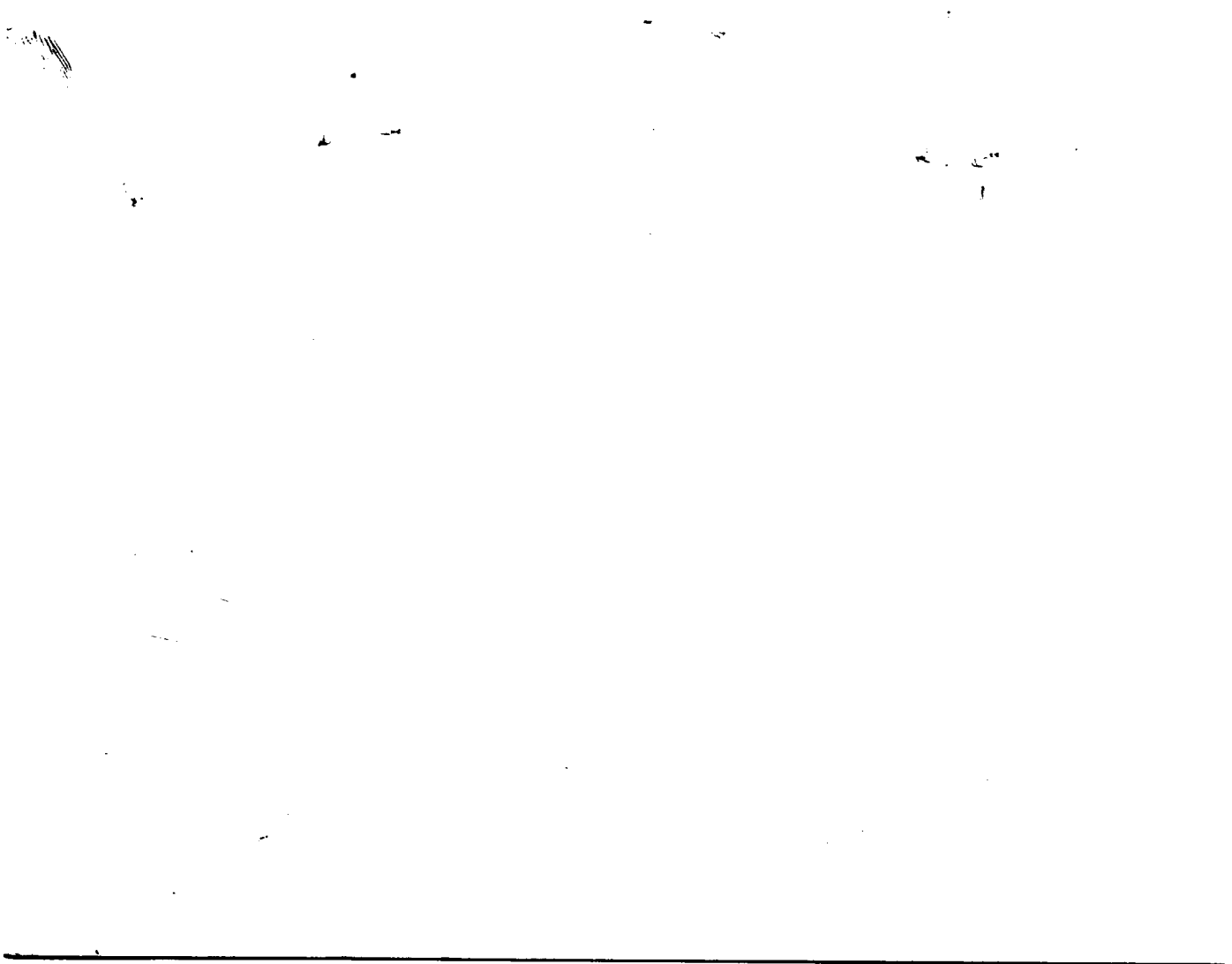
_____, 19____

Registrar.

Address _____

Filed 7/1/23 1923

Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

JUN

CERTIFICATE OF DEATH

BUREAU Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 42515
Registered No. 85

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filled

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

693-2041235-455
PLACE OF BIRTH

RECEIVED

JUN 9 1923

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Blaine

City of Leicester

No. _____ St. _____

Registration District No. _____

File No. _____

Hospital St. Joseph

Primary Registration District No. 1009

Registered No. 86

FULL NAME OF CHILD

(stillborn) Emily Cecelia Wilson

(Certificate of no value without full name of child.)

Sex of
Child Female

Twin
Triplet
or other?

and
Number
in order
of birth

Legiti-
mate? yes

Date of
birth

June 4 1923
(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. 3

Number of child of this mother now living, including present birth. 2

FULL
NAME

FATHER

Arnon W. Wilson

FULL
MAIDEN
NAME

MOTHER

Grace Menger

RESIDENCE

Clarkston

RESIDENCE

same

COLOR

white

AGE AT LAST
BIRTHDAY

37
(Years)

COLOR

w.

AGE AT LAST
BIRTHDAY

29
(Years)

BIRTHPLACE

Indiana

BIRTHPLACE

Colorado

OCCUPATION

Architect

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn, at _____ M.
on the date above stated.

(Born at _____)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Paul W. Johnson

(Physician or midwife)

Give names added from a supplemental report.

Address

Leicester, Idaho

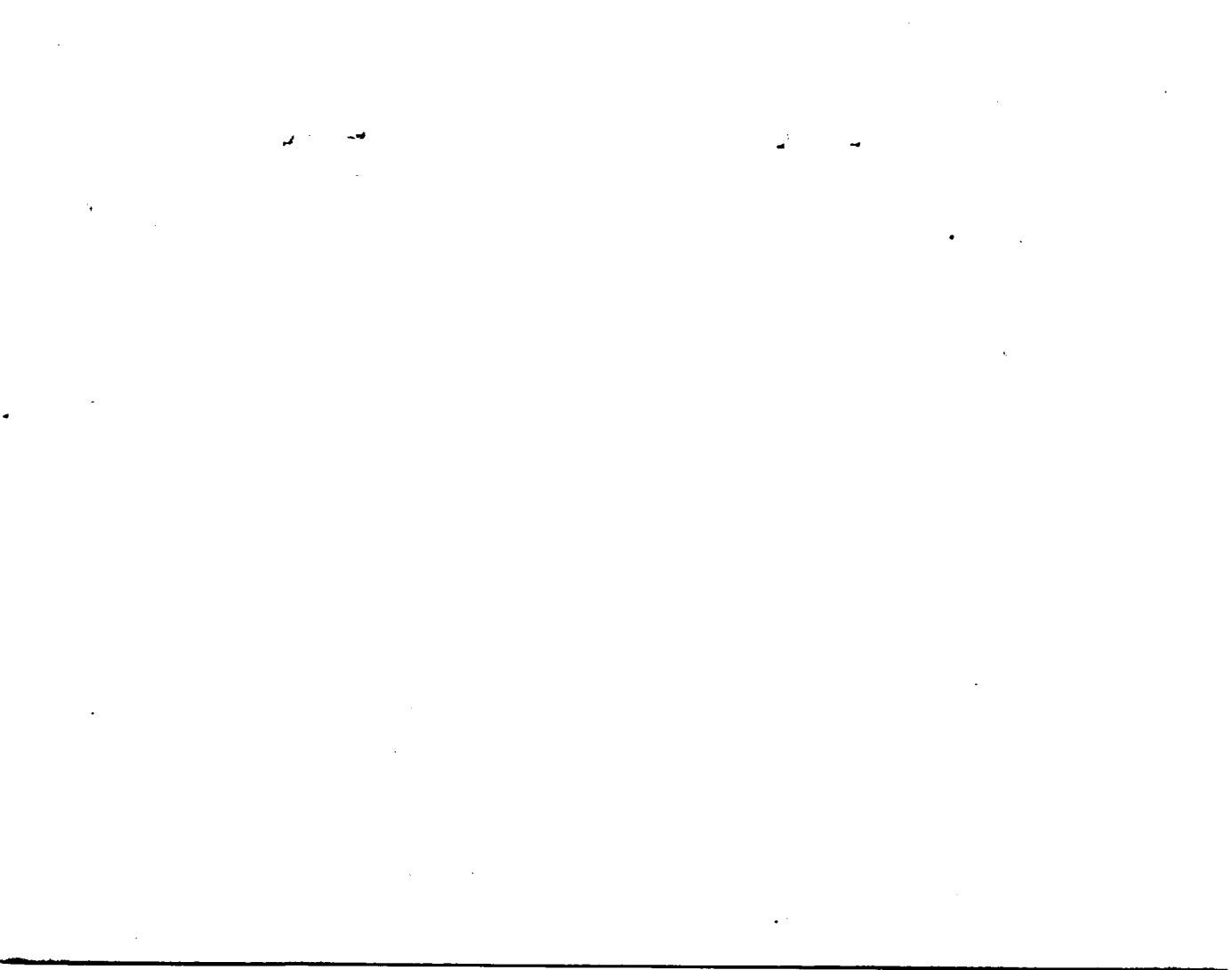
Filed

7/1/23

192

Registrar.

Registrar.



RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Payson*City of *Leibster*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alma Cecelia Wilson

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

286-109,035-235

PLACE OF BIRTH

RECEIVED

JUN 5 1923

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-8-9-17

County of *Key Perce*

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

*S*113105

City of *Caldesae*

Registration District No.

File No.

No. St.

Primary Registration District No.

Registered No.

Hospital

Caldesae & Vicinity

FULL NAME OF CHILD

Sex of Child <i>Male</i>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <i>yes</i>	Date of Birth <i>4 9 1923</i> (Month) (Day) (Year)
-----------------------------	---	---	---------------------------	--

FULL NAME <i>William Richard Shores</i>	FATHER
RESIDENCE <i>Caldesae Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>26</i> (Years)
BIRTHPLACE <i>Oklahoma</i>	
OCCUPATION <i>Blacksmith</i>	

FULL MAIDEN NAME <i>Maytha Stewart</i>	MOTHER
RESIDENCE <i>Caldesae Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>22</i> (Years)
BIRTHPLACE <i>Idaho</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth....*2* Number of children of this mother now living, including present birth....*1*.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was....*Stillborn*....., at *11:00 P.* M. on the date above stated.
(Born alive or stillborn)

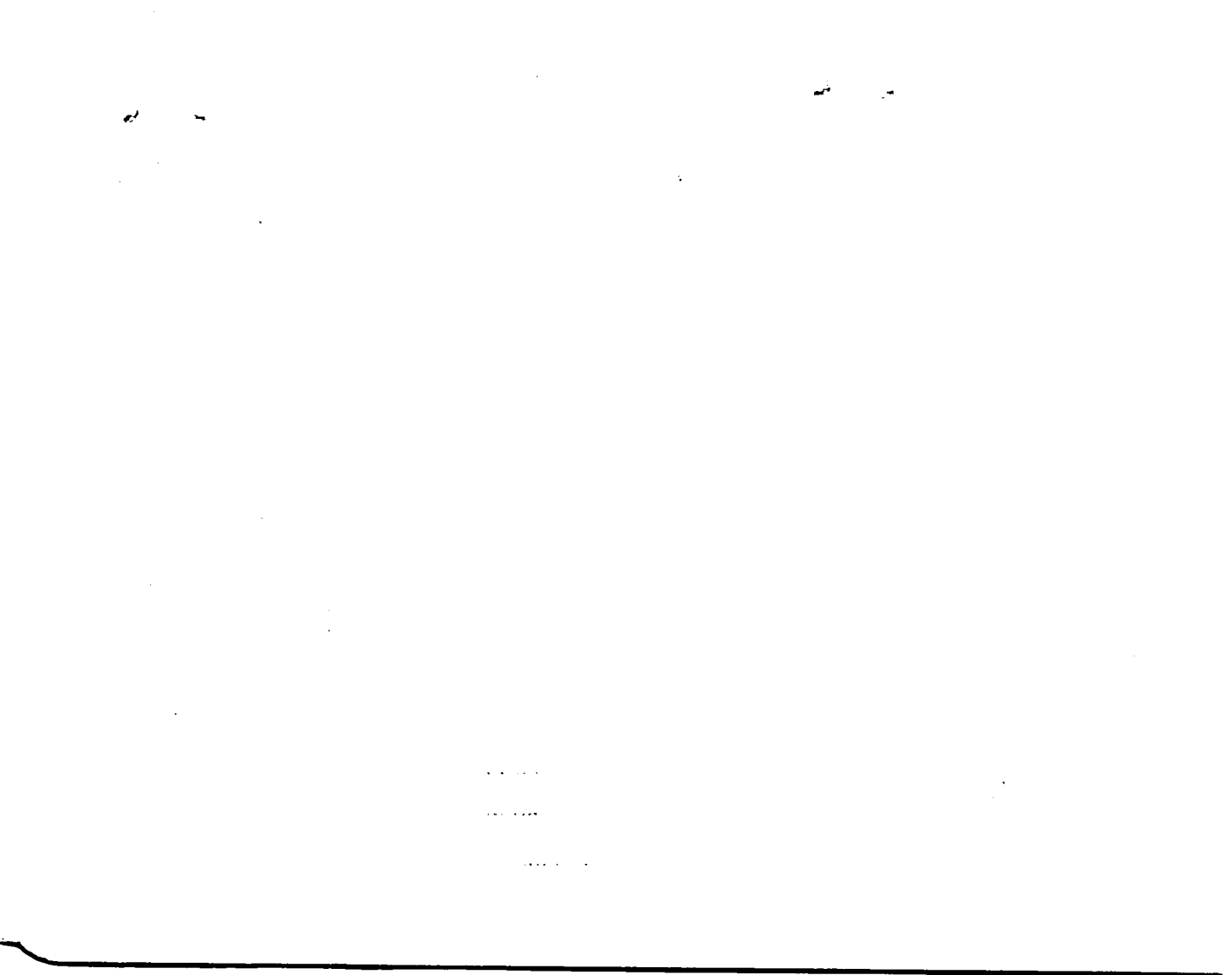
*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *George Guignard*
.....
(Physician or midwife)

Given names added from a supplemental report.

.....
.....
.....
Registrar

Address *Caldesae Idaho*
.....
Filed *April 23 1923*
.....
Registrar



WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

Form V. S. No. 5. 12½ M. 7-24-11

1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH Key Bence Registration District No. 128
County of Key Bence Primary Registration District No. Caldwell & vicinity
City of Caldwell (No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42518
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH 4 9 1923
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ Stillbirth

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER William R. Shores

11. BIRTHPLACE OF FATHER

(State or Country) Oklahoma

12. MAIDEN NAME OF MOTHER Martha Stewart

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Shores
(Address) Caldwell Idaho

15. Filed April 1923 George Gagnard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 4 9 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191____, to 191____

that I last saw h_____ alive on 191____ and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillbirth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) George Gagnard M. D.
April 1923 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Caldwell Idaho 4-9-1923

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

469-03-035-168
PLACE OF BIRTH

RECEIVED

JUN 26 1923

BUREAU OF VITAL
STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of JeffersonCity of Meridian

No. _____ St. _____

Registration District No. _____

File No. 113117Hospital St. JosephPrimary Registration District No. 1009Registered No. 687FULL NAME OF CHILD (Sheelborn) Morris (Indian)

(Certificate of no value without full name of child.)

Sex of
Child _____Twin
Triplet
or other?{ and } Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mated _____Date of
birth _____

(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth. 1Number of child of this mother now living, including present birth. 0FULL
NAME

FATHER

Phillip Morris

RESIDENCE

State 244

COLOR

Indian

AGE AT LAST

BIRTHDAY _____ (Years)

BIRTHPLACE

Idaho

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

Agnes Johnson
State

COLOR

Indian

AGE AT LAST

BIRTHDAY _____ (Years)

BIRTHPLACE

Idaho

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____
on the date above stated. (Born alive or stillborn)

8 P. M.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) _____

E. S. Braddock

(Physician or midwife)

Give names added from a supplemental report.

Address _____

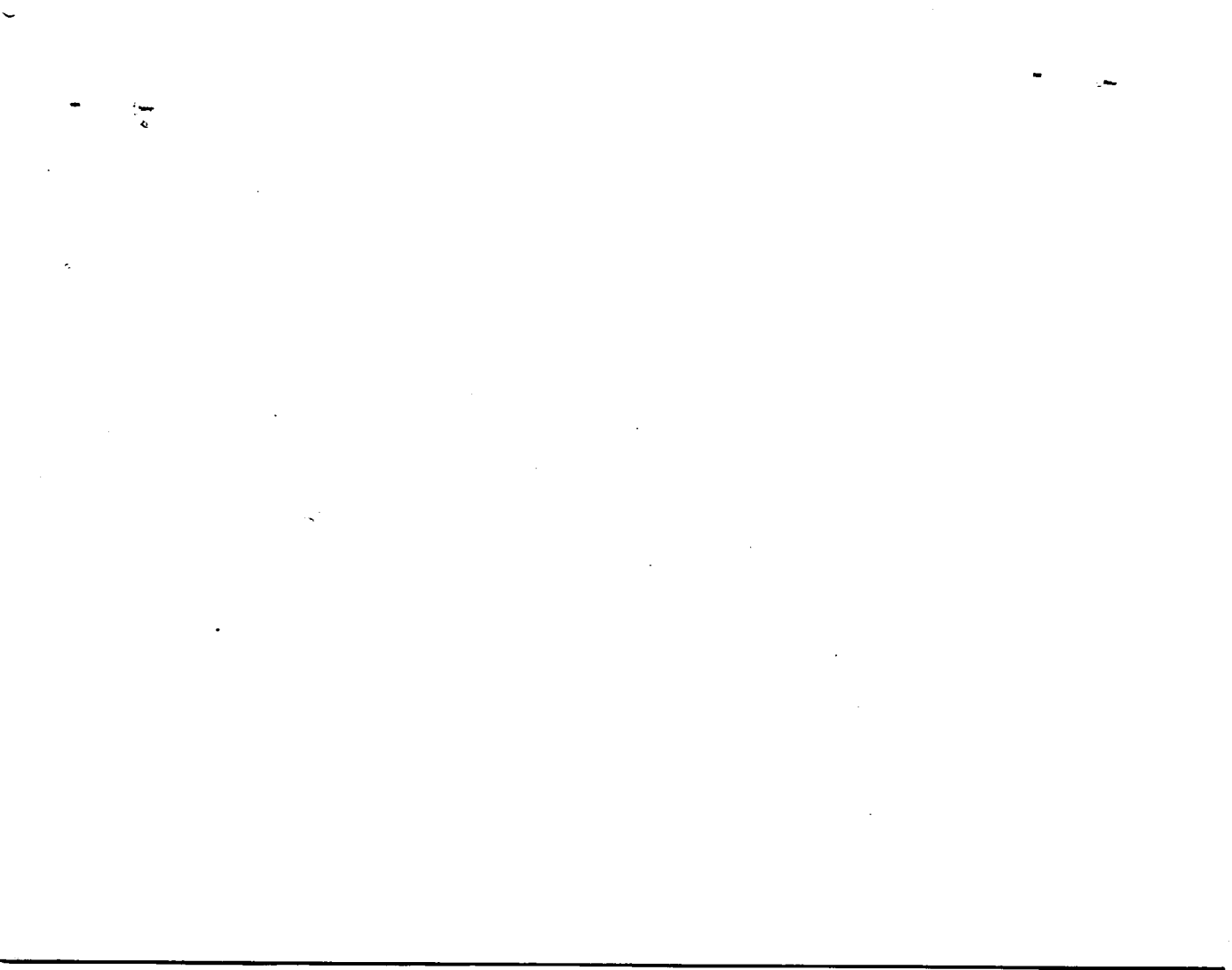
Levensworth, Idaho

Filed _____

6/1/23 192__William H. H. H.

Registrar.

Registrar.



FC

A. 1-16-18

REC

1. PLACE OF DEATH

County of

No.

City of

Registration District No.

1009

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Morris

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

425014

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

May 3 1923
(Month) (Day) (Year)

7. AGE

Still Birth

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Philip Morris

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Agnes Johns

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

6/23

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 3 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1923, to May 3 1923, that I last saw ~~her~~ alive on May 3 1923 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ely Bradstock M. D.

May 9 23 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

State Idaho

7/5 1923

20. UNDERTAKER

ADDRESS

Vassen and Co.

Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

462-112 1036-356
PLACE OF BIRTHCounty of OreidaCity of Daniel

No. St.

Hospital

FULL NAME OF CHILD

RECEIVED

JUN 25 1923

BUREAU OF VITAL

Registration District No.

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Form V. S. No. 11-C-21m-6-8-17

S

File No. 113134Registered No. 51Primary Registration District No. 2069

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>5-12-23</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

FULL NAME <u>Ermest Mars</u>	FATHER
RESIDENCE <u>Daniel Id</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)
BIRTHPLACE <u>Schweitzerland</u>	
OCCUPATION <u>Farmers</u>	

FULL MAIDEN NAME <u>Mary Tew</u>	MOTHER
RESIDENCE <u>Daniel Id</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>England</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth... 3Number of children of this mother now living, including present birth... 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) T. M. Kerp

(Physician or midwife)

Given names added from a supplemental report.

Address Daniel IdFiled June 15 1923

Registrar

Registrar B. T. Mauer M.D.

RECEIVED FOR
RECORDING
RECEIVED FOR
RECORDING

PLACE OF BIRTH

DATE OF BIRTH

SEX

RELATIONSHIP TO HEAD OF FAMILY

EDUCATION

EMPLOYMENT

RESIDENCE

DATE OF ENTRY

REMARKS

DECLARATION OF ALLEGIANCE

SIGNATURE OF HEAD OF FAMILY

SIGNATURE OF NATURALIZATION OFFICIAL

DATE OF NATURALIZATION

PLACE OF NATURALIZATION

REMARKS

PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

61 3-226-036-619
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Oneida

City of Malad

No. St. Registration District No. 26 State File No. 113141-B

Hospital..... Primary Registration District No. 2069 Local Registrar's No.

FULL NAME OF CHILD..... (Stillborn)

(Certificate of no value without full name of child.)

Sex of Child	<u>Female</u>	Twin <u>twin</u> Triplet <u>and</u> or other? <u>Number in order of birth</u> (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>5</u> <u>26</u> (Month) (Day)	<u>1923</u> (Year)
--------------	---------------	--	------------------------	---	-----------------------

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth.....	
FATHER FULL NAME <u>Wm. S. Waldron</u>		MOTHER FULL MAIDEN NAME <u>Amy S. Ware</u>	
RESIDENCE <u>Gwenford, Ida.</u>		RESIDENCE <u>Gwenford</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Gwenford, Ida.</u>		BIRTHPLACE <u>Darane, Wis.</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 1:55 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. M. Kerns

M. D.
(Physician or midwife)

Give names added from a supplemental report.

Address Malad

Filed June 15 1923 R. T. MAUER, M. D.

Registrar.

Registrar.

STATE OF NEW YORK
DEPARTMENT OF PUBLIC SAFETY
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration Number No. 55 State File No. 11311-3

Fraser's Registration District No. 3000

(211104)

REF ID: A66666

(Certificate of Release Without Full Name of Child)

[illegible]

...fancy of some new molecule (abstracted last)

Number of birds of this species now living, including present birds

FULL NAME	FATHER	FULL NAME	MOTHER
NAME		NAME	NAME

RESIDENCE

bio in evs

10	LAST TA 25A BIRTHDAY	COLOR	10	LAST TA 25A BIRTHDAY	COLOR
----	-------------------------	-------	----	-------------------------	-------

BIRTHPLACE BIRTHPLACE

21, 1950

10-10-68

91743009

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

on the date above stated.

(S) When there was no attending physician at midnight, then the latter doctor.

J. M. News

When there was no attending physician at midnight, the patient's condition was reported as stable. A small amount of blood was noted in the stool. The patient was given a small amount of food and was comfortable.

(Return to sender)

Give names added from a report: "port"

Page 10
J. E. HANSEN, JR.
Register

[illegible]

849-224-038-883
PLACE OF BIRTH

RECEIVED
JUN 5 1923
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

113185

County of Payette

City of Warr Plymouth

No. _____ St. _____

Registration District No. _____

File No. _____

Hospital _____

Primary Registration District No. 1009

Registered No. 21

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>7</u>	Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input checked="" type="checkbox"/> { and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 24</u> 192 <u>3</u> (Month) (Day) (Year)
-----------------------	--	------------------------	---

What bactericidal solution was used in eyes? argyrol

Number of child of this mother, including present birth 40 Number of child of this mother now living, including present birth 3

FULL NAME FATHER Gwin Hurle

FULL MAIDEN NAME MOTHER May Hylton

RESIDENCE Warr Plymouth Ida

RESIDENCE with husband

COLOR w AGE AT LAST BIRTHDAY 30 (Years)

COLOR w AGE AT LAST BIRTHDAY 25 (Years)

BIRTHPLACE Lorra

BIRTHPLACE mo.

OCCUPATION Section hand on O.S.

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born dead at 12:30 P. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Wm J. Drysdale MD

(Physician or midwife)

Give names added from a supplemental report.

Address Warr Plymouth Ida

Filed 6/27 1923 Wm J. Drysdale Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

These premature twins were properly reported & recorded as still births - unnamed. The mother brought this to me for explanation.

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Wm J. Drysdale

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY _____
(ST. _____
(COUNTY _____
FATHER _____

FILE NO. 113185
DATE OF BIRTH _____
SEX OF CHILD Female
MOTHER _____

(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

RECEIVED
JUL 27 1923
BUREAU OF VITAL
STATISTICS

Signature of Father or Mother

12 -
an
e

DATE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

JUN 5 1923

Registration District No. 5

BUREAU OF VITAL STATISTICS

Primary Registration District No. 1009

File No. 42526

County of PayetteCity of New Plymouth

(No. , St.)

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Hurree

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 24 1923
(Month) (Day) (Year)

7. AGE

Stillborn

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Gwin Hurree

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

May Hylton

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

May Hylton Hurree

(Address)

New Plymouth Ida

15.

Filed 6/29

1923

Wm J. Drysdale
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 24 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
at birth 191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Unknown - 7 mo. gestation -
maceration of skin indicated
death in utero -

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm J. Drysdale M. D.6/29 1923 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Plymouth Ida 6/24 1923

20. UNDERTAKER

Father of infant

ADDRESS

New Plymouth

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

849-224-238-883
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JUN 5 1923
CERTIFICATE OF BIRTH

S

County of Payette
City of New Plymouth
No. _____ St. _____
Hospital _____
Primary Registration District No. 1009
Registered No. 22
File No. 112186

FULL NAME OF CHILD Infant Hurree
(Certificate of no value without full name of child.)

Sex of Child <u>7</u>	Twin <input checked="" type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/>	and {	Number in order of birth <u>2</u>	Legitimate? <u>Yes</u>	Date of birth <u>June 24</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FULL NAME <u>Irvin Hurree</u>	FATHER	FULL MAIDEN NAME <u>May Hylton</u>	MOTHER
RESIDENCE <u>New Plymouth Ida</u>		RESIDENCE <u>with husband</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Mo.</u>	
OCCUPATION <u>R R Section Hand</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born dead at 1 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

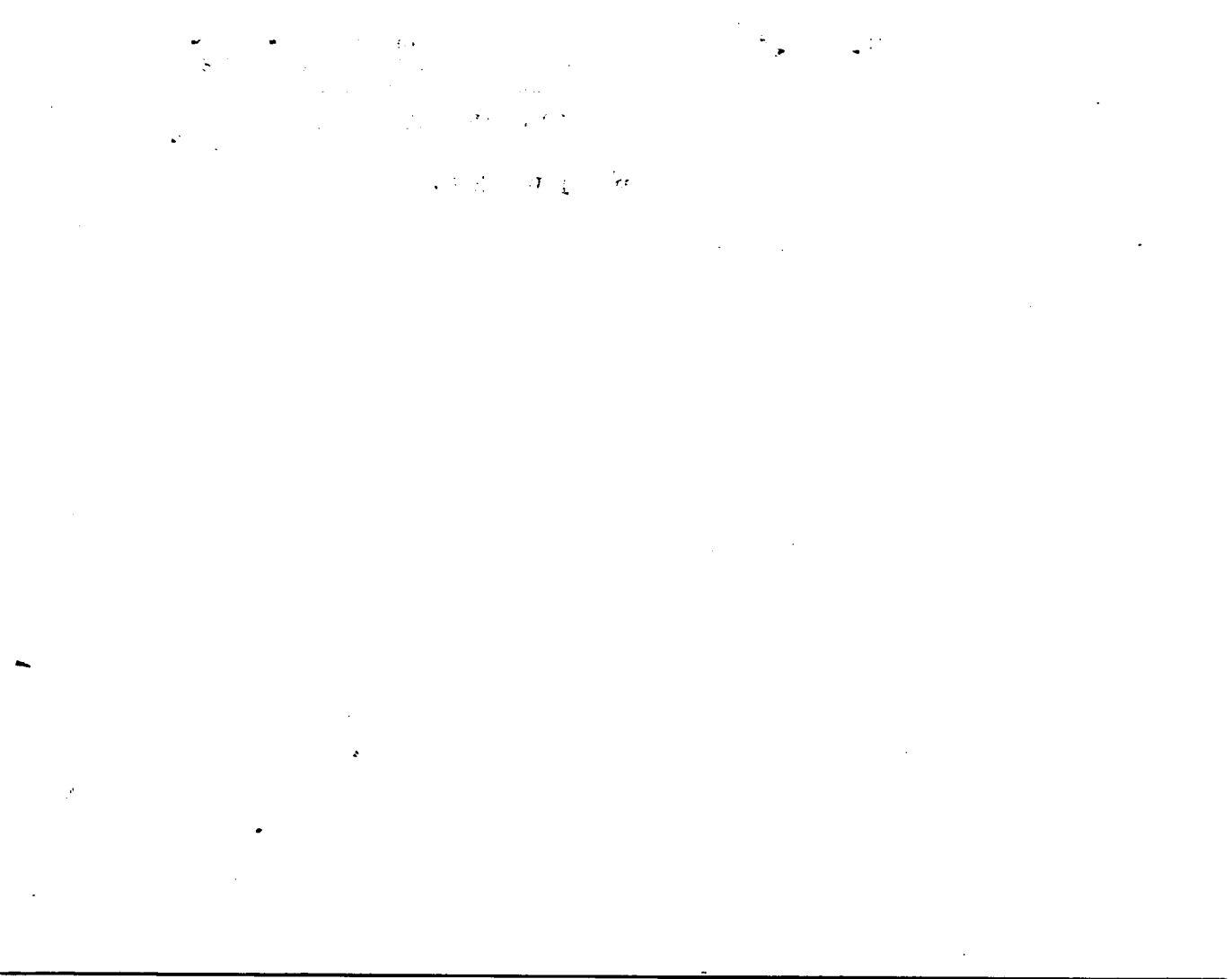
(Signature) Wm J. Drysdale M D

(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address New Plymouth Ida
Filed 6/29 1923 Wm J. Drysdale
Registrar.



STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

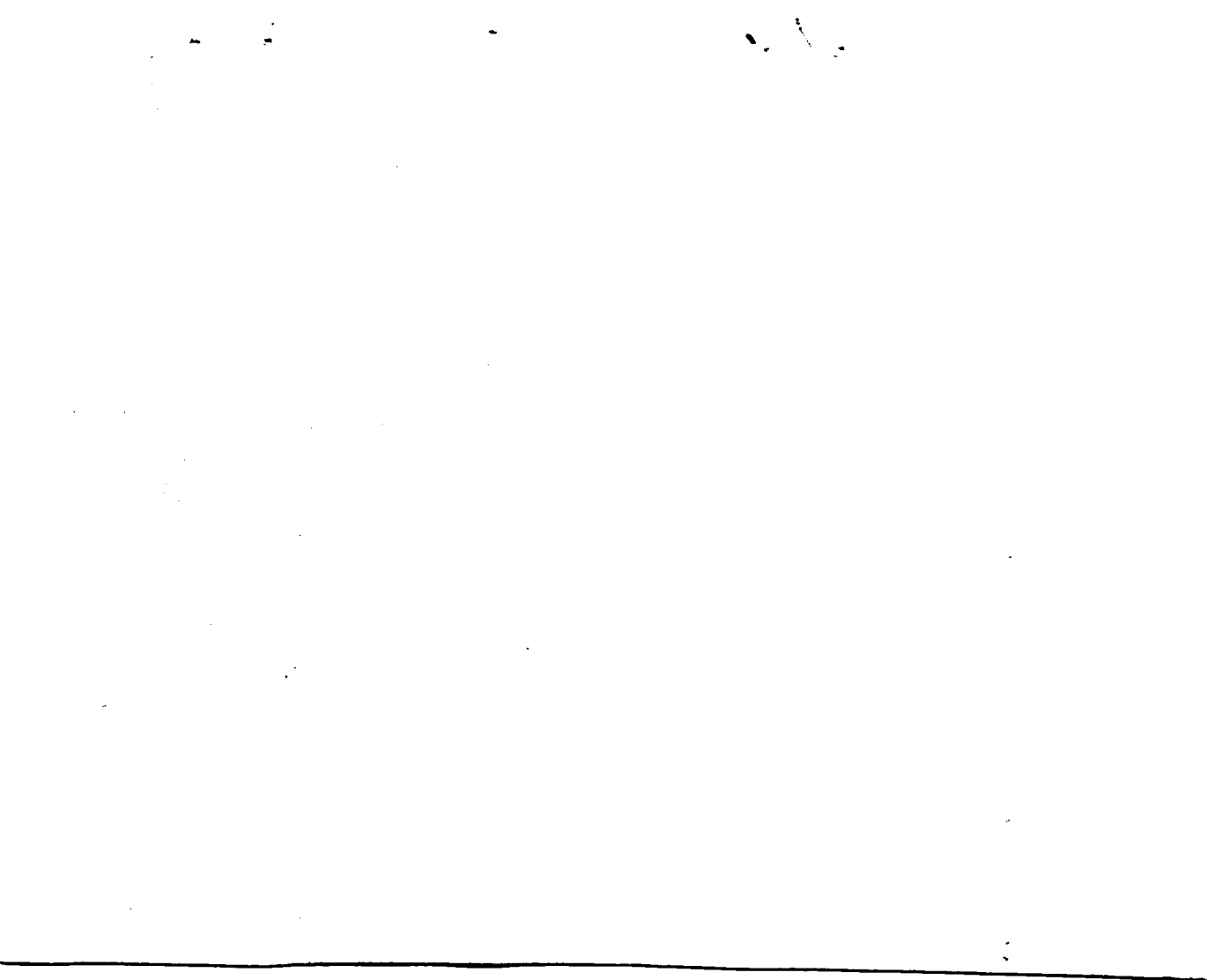
BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY _____	FILE NO. <u>113186</u>
	(ST. _____	DATE OF BIRTH _____
	(COUNTY _____	SEX OF CHILD <u>Female</u>
	FATHER _____	MOTHER _____ (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Signature of Father or Mother



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
JUN 2 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42527
Registered No. 6
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 5
County of Payette Primary Registration District No. 1009
City of Dr. Plymouth (No. St.)
If death occurs away from usual residence, give facts called for under special information.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH June 24 1923 (Month) (Day) (Year)
7. AGE Stillborn yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.
8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE Idaho (State or Country)
10. NAME OF FATHER Givie Hurree
11. BIRTHPLACE OF FATHER Iowa (State or Country)
12. MAIDEN NAME OF MOTHER May Hylton
13. BIRTHPLACE OF MOTHER Mo. (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May Hylton Hurree
(Address) Dr. Plymouth Ida
15. Filed 6/29 1923 Wm J. Dupdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 24 1923 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from at birth 191. to 191., that I last saw h. alive on 191., and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Unknown - 7 mo gestation
maceration of skin indicated
death in utero.
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Wm J. Dupdale M. D.
6/29 1923 (Address) Dr. Plymouth.
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.
19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Dr. Plymouth 6/24 1923
20. UNDERTAKER ADDRESS
father of infant Dr. Plymouth

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

62-121-042-433

PLACE OF BIRTH

County of Shoshone

City of Wallace

No. _____ St. _____

Hospital Providence

FULL NAME OF CHILD

RECEIVED
JUN 9 1923

BUREAU OF VITAL
STATISTICS

Registration District No. 70

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Form T. S. No. 11-C-2m-3-15-13

S

113190

File No. _____

Registered No. 64

Primary Registration District No. 1011

Steebourn

Sex of Child <u>m</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>May 2</u> 19 <u>23</u> (Month) (Day) (Year)
-----------------------	---	------------------------------------	------------------------	---

FULL NAME <u>Leo J. Hoban</u>	FATHER
RESIDENCE <u>Wallace</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Missouri</u>	
OCCUPATION <u>Accountant</u>	

FULL MAIDEN NAME <u>Aida Marie Mc Carthy</u>	MOTHER
RESIDENCE <u>Wallace</u>	
COLOR <u>m</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Wash</u>	
OCCUPATION <u>Idm</u>	

Number of child of this mother, including present birth. _____

Number of children of this mother now living, including present birth. _____

CERTIFICATE OF ATTENDING PHYSICIAN

I hereby certify that I attended the birth of this child, who was _____ on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

F. L. Dwyer

(Physician or midwife)

Given names added from a supplemental report

_____ 19 _____

Address _____

Filed

May 23 1923 F. L. Dwyer
Registrar

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

RECEIVED

CERTIFICATE OF DEATH

✓ State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **JUN 9 1923** Registration District No. **70**
County of **Shoshone** BUREAU OF VITAL STATISTICS Primary Registration District No. **1011**
City of **Wallace** (No. **Providence Hospital** St.)

File No. **42534**
Registered No. **78**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Son of Mr. & Mrs. J. Hoban

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **White** **Single**
(Write the word.)

6. DATE OF BIRTH

May **21** **1923**
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Leo J. Hoban

11. BIRTHPLACE OF FATHER

(State or Country) **Minn**

12. MAIDEN NAME OF MOTHER

Anita McCarthy

13. BIRTHPLACE OF MOTHER

(State or Country) **Washington**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leo J. Hoban

(Address)

Wallace Idaho

15. FILED

May 21 **1923** **J. L. Dunsley**
Local Registrar

16. DATE OF DEATH

May **21** **1923**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Still born

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. L. Dunsley M. D.
5/21/23 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane Washington **5-22-1923**

20. UNDERTAKER

ADDRESS

B. G. Forstell **Wallace Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

285-126-042-266
PLACE OF BIRTH

RECEIVED
JUN 25 1923
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Turn Falls

City of Buhl

No. _____ St. _____

Hospital _____

Registration District No. 39

File No. _____

Primary Registration District No. 20878

Registered No. _____

FULL NAME OF CHILD _____

Bobby Eugene S. Herman
(Certificate of no value without full name of child.)

Sex of Child Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? Yes

Date of birth 5-26-1923
(Month) (Day) (Year)

What bacterioidal solution was used in eyes? Angelol

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

FULL NAME FATHER Lewis C. S. Herman

FULL MAIDEN NAME MOTHER Bessie Bowcutt

RESIDENCE Buhl, Id.

RESIDENCE Buhl, Id.

COLOR Whl AGE AT LAST BIRTHDAY 26
(Years)

COLOR Whl AGE AT LAST BIRTHDAY 23
(Years)

BIRTHPLACE Nesbr.

BIRTHPLACE Utah

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 11 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Geo. Jennings, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Buhl, Id.

Filed MAY 31 1923 J. H. Murphy

Registrar.

Registrar.

1. HALL TO 1. HALL
1. HALL TO 1. HALL

Boise, Idaho 7/16 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Buhl FILE NO. 113271
(ST. _____ DATE OF BIRTH May 26 1923.
(COUNTY Lincoln Falls SEX OF CHILD Male
FATHER L. E. Sherman MOTHER Bessie A. Bowcutt
(Maiden Name)

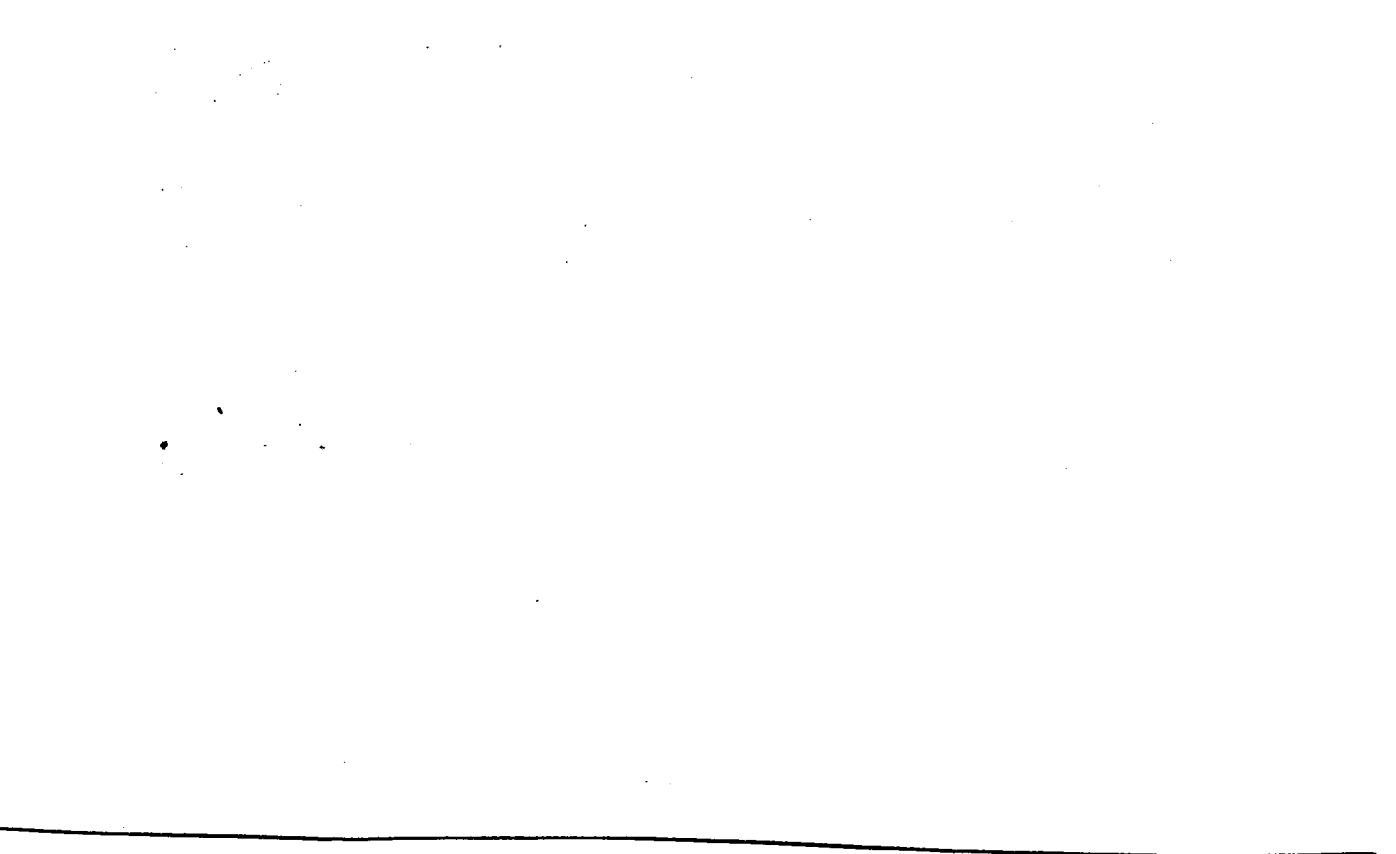
I HEREBY CERTIFY that the child herein described has been named:

Bobby Eugene Sherman

L. E. Sherman

Signature of Father or Mother.

REIVED
23 1923
U OF VITAL
ICS



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

 County of Boone Registration District No. 39
 City of Bull Registration District No. 2087 St.
File No. 13577Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Sherman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

May 26 1923
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

 IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).
None

9. BIRTHPLACE

(State or Country)

Bull

10. NAME OF FATHER

Lewis E. Sherman

11. BIRTHPLACE OF FATHER

(State or Country)

Nebr.

12. MAIDEN NAME OF MOTHER

Bessie Rowcutt

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. R. Sherman

(Address)

Bull, Ida.

15.

Filed 5-27 1923

Local Registrar

J. N. Murphy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5-26-23
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-26-1923 to 5-26-1923

 that I last saw him alive on 5-26-1923

 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

George J. Janning M. D.
5-27-23 (Address) Bull, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bull Cemetery5-27-1923

20. UNDERTAKER

ADDRESS

Smith & DuggBull, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

154-104.042-719

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICSCounty of Twin Falls

JUN 3 1923

CERTIFICATE OF BIRTH

S

City of Twin Falls

BUREAU OF VITAL

37.

No. 1420 8th St. E.

Registration District No.

File No. 113286

Hospital

Primary Registration District No. 1085 Registered No.FULL NAME OF CHILD not namedSex of Child maleTwin
Triplet
or other?
(To be answered only in event of plural births)and { Number
of birth
(To be answered only in event of plural births)Legiti
mate? yesDate of Birth June 4 1923
(Month) (Day) (Year)FULL
NAMEFATHER
Sidney D. Anderson

RESIDENCE

Twin Falls

COLOR

whiteAGE AT LAST
BIRTHDAY42

(Years)

BIRTHPLACE

Utah

OCCUPATION

BarberFULL
MAIDEN
NAMEMOTHER
Annie O. Parkinson

RESIDENCE

Twin Falls

COLOR

whiteAGE AT LAST
BIRTHDAY40

(Years)

BIRTHPLACE

Utah

OCCUPATION

HousewifeNumber of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born, at 4:30 P.M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Hal Bieler
M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Twin Falls, Ida.

Filed

July 1- 1923

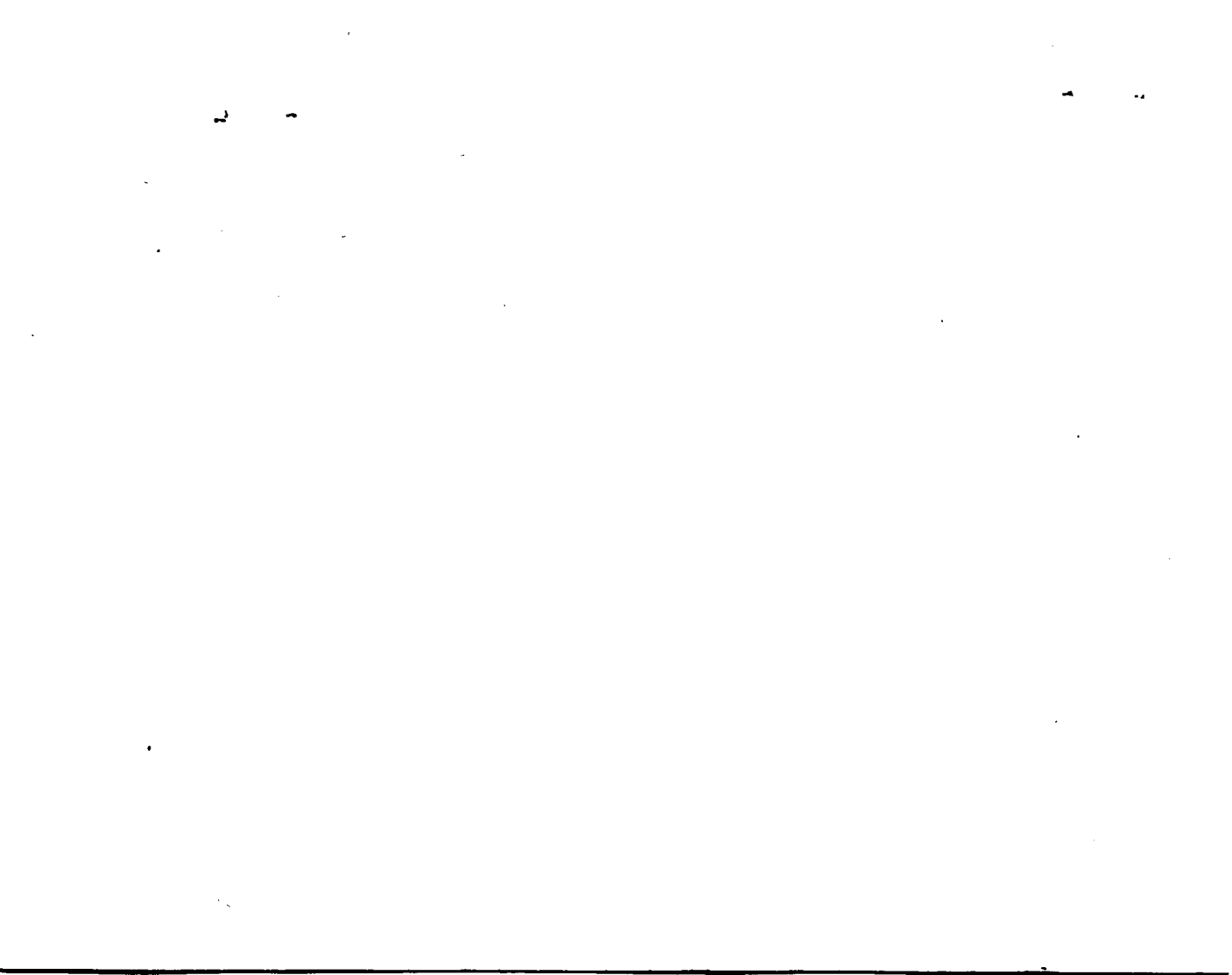
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



1. PLACE OF DEATH

County of *Twin Falls*City of *Twin Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *37*Primary Registration District No. *1085*

St.)

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *42559*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

June 4 1923
(Month) (Day) (Year)

7. AGE

9 Mos. in utero
Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Twin Falls, Ida.

10. NAME OF FATHER

Sidney D. Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Anne C. Parkinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Hal Bieler
Twin Falls, Ida.

(Address)

15.

Filed

*July 1 1923**John H. Longley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

in 19..... to 19.....
that I last saw ~~him~~ on *June 4* 1923.,
and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH* was as follows:

Still birth; premature detachment of placenta, which occurred probably 3 weeks before birth.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Deformed uterus.

(Duration) yrs. mos. ds.

(Signed)

*Hal Bieler M. D.**June 30 1923* (Address) *Twin Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls.

DATE OF BURIAL

June 4 1923

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

645-106.001-155
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S113436

County of Ada

City of Eagle

No. _____ St. _____

AUG

BUREAU OF

STATISTICS

Registration District No. 9+10

File No. 52

Hospital _____

Primary Registration District No. 9+10

Registered No. 52

FULL NAME OF CHILD

Walter Odermatt

Sex of Child

MALE

Twin
Triplet
other?

and

Number
in order
of birth

1st

Legiti-
mate?

yes

Date of
Birth

July 6

1923

(To be answered only in event of plural births)

(Month) (Day) (Year)

FULL
NAME

FATHER

Walter Odermatt

RESIDENCE

Eagle

COLOR

white

AGE AT LAST
BIRTHDAY

36
(Years)

BIRTHPLACE

Switzerland

OCCUPATION

Rancher

FULL
MAIDEN
NAME

MOTHER

Lerna Lentz

RESIDENCE

Eagle

COLOR

white

AGE AT LAST
BIRTHDAY

29
(Years)

BIRTHPLACE

Poland

OCCUPATION

Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Stillborn at 11:40 P. M.
(Born alive or stillborn)

(Signature)

Georck Haack M.D.

Physician

(Physician or midwife)

Given names added from a supplemental report.

19 _____

Address

Eagle

Filed

7/8

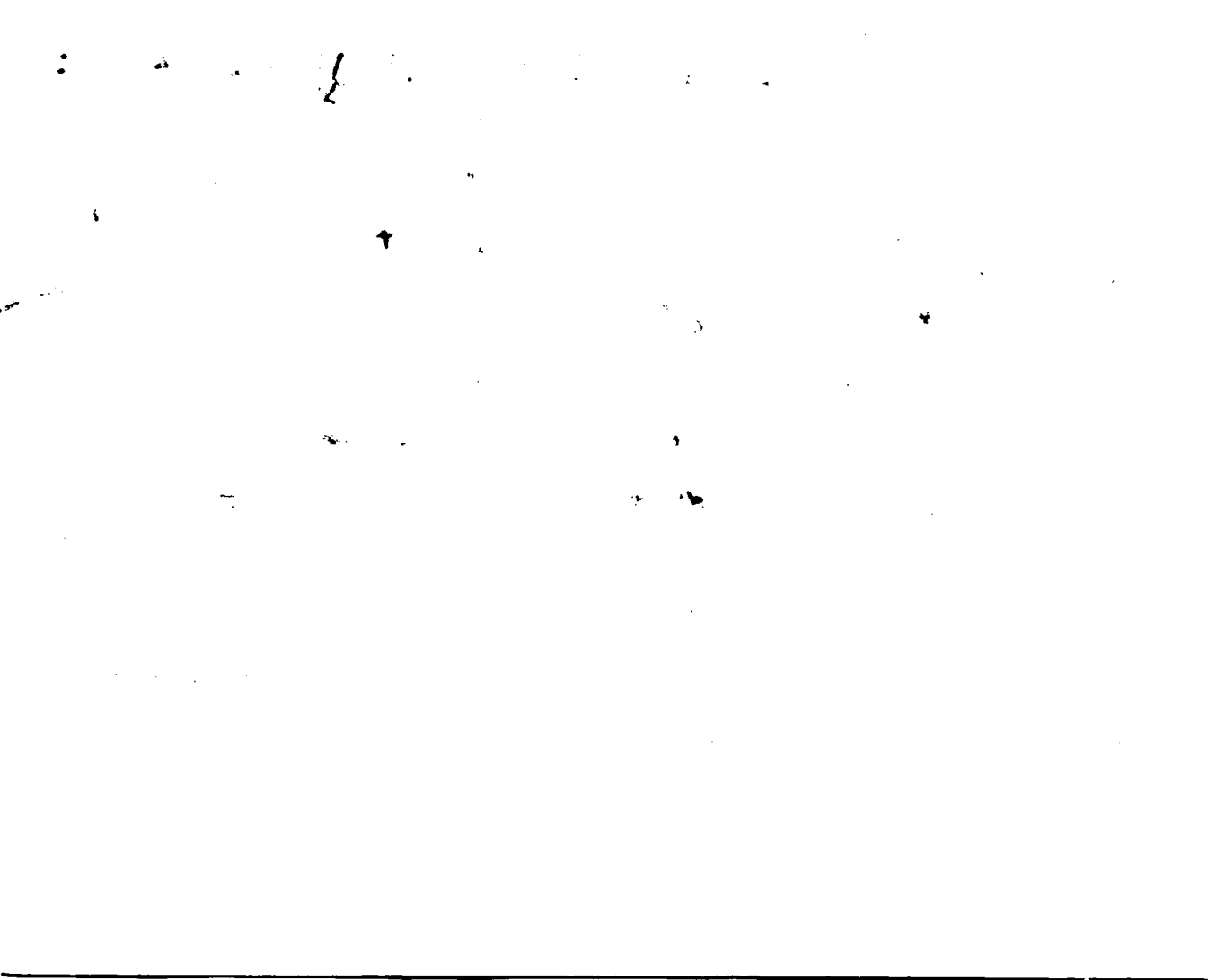
19 _____

23 Orville Jackson

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.



CERTIFICATE OF DEATH

42614 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9-10

County of Ada

Primary Registration District No. 9-10

File No. 38

City of Eagle

(No. St.)

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter

Odermott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Stillborn July 6

(Month)

(Day)

1923 (Year)

7. AGE

8 1/2 months gestation

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Eagle, Ada

10. NAME OF FATHER

Walter Odermott

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Lena Jentz

13. BIRTHPLACE OF MOTHER

(State or Country)

Poland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Odermott

(Address)

Eagle, Idaho

15.

Filed

7/8

19

Orville J. Jenson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn July 6

(Month)

(Day)

1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 6 1923, to July 6 1923

that I last saw him alive on Stillborn July 6 1923,

and that death occurred on the date stated above, at 1:40 P.M.

The CAUSE OF DEATH* was as follows:

Stillborn July 6 1923

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Not Known

(Duration) yrs. mos. ds.

(Signed)

Dr. H. H. Hall

M. D.

July 6 1923

(Address)

Eagle

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonair

DATE OF BURIAL

7/8 1923

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

645-106.001-155
PLACE OF BIRTH:

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 113437

County of Ada AUG 8 1923City of EagleBUREAU OF VITAL
STATISTICSRegistration District No. 9+10File No. 51

No. _____ St. _____

Primary Registration District No. 9+10Registered No. 51

Hospital _____

FULL NAME OF CHILD August OdermottSex of
Child MALETwin
single?
(To be answered only in event of plural births)and
Number
in order
of birth 2ndLegiti-
mate? yesDate of
Birth July 6(Month) (Day) (Year) 1923FULL
NAME WalterFATHER OdermottFULL
MAIDEN
NAME AnnaMOTHER JennyRESIDENCE EagleRESIDENCE EagleCOLOR whiteAGE AT LAST
BIRTHDAY 36

(Years)

COLOR whiteAGE AT LAST
BIRTHDAY 29

(Years)

BIRTHPLACE SwitzerlandBIRTHPLACE PolandOCCUPATION MinerOCCUPATION HousewifeNumber of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:55 P. M.
on the date above stated. (Born alive or stillborn)*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.(Signature) Wm H HallPhysician

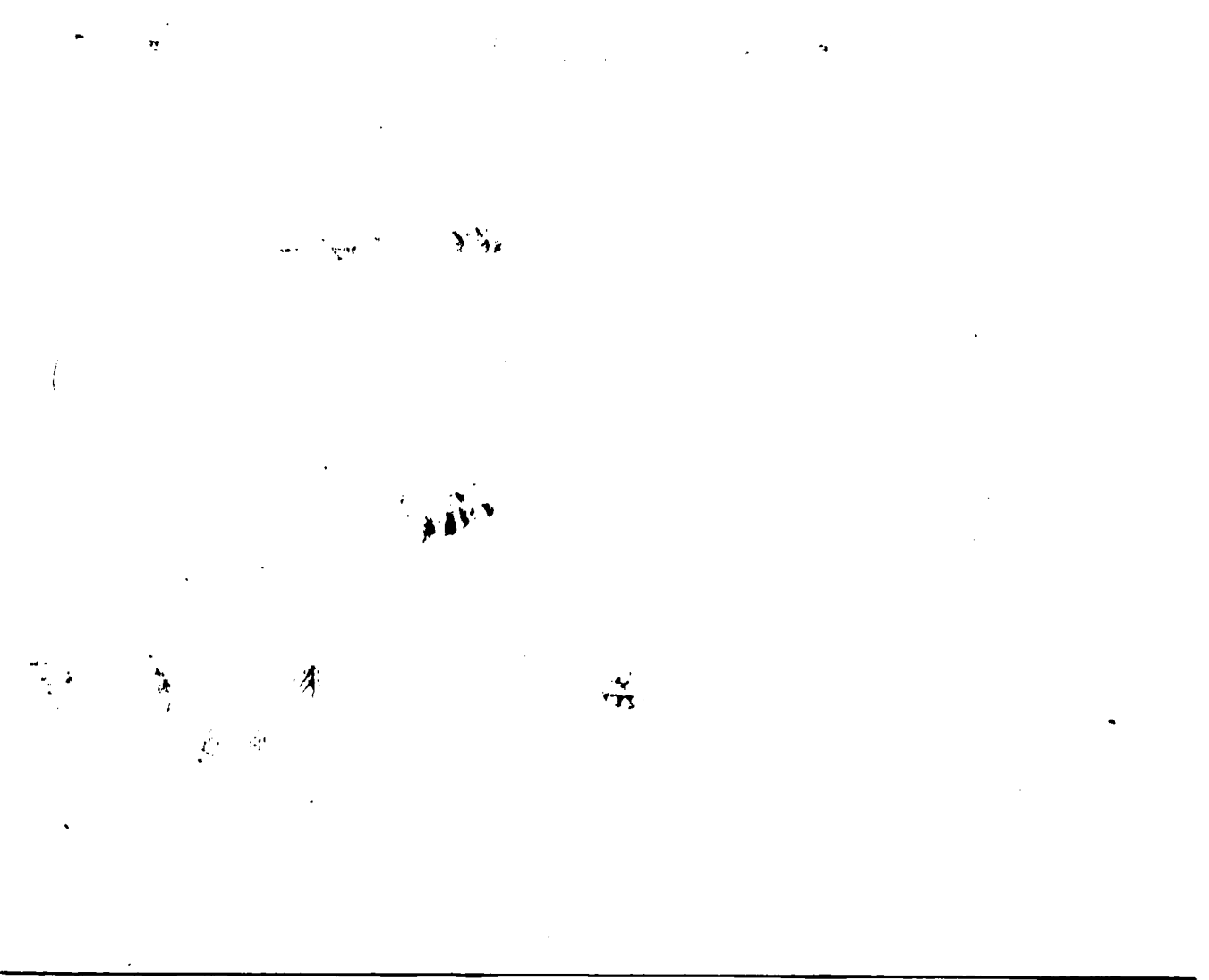
(Physician or midwife)

Given names added from a supplemental report. _____ 19. _____

Address EagleFiled 7/1819. 23

Registrar. _____

Registrar. Earl J. Hall



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Ada

City of Eagle

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

AUG 8

BUREAU OF VITAL STATISTICS

Registration District No. 9-10

Primary Registration District No. 9-10

City of Eagle St.)

2. FULL NAME August Odermatt

File No. 29

Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Stillborn July 6

(Month)

(Day)

1923
(Year)

7. AGE

8 1/2 months gestation

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Eagle Ida

10. NAME OF FATHER

Walter Odermatt

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Anna Jenty

13. BIRTHPLACE OF MOTHER

(State or Country)

Poland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Odermatt

(Address) Eagle Idaho

15.

Filed

7/8

1923

Annie Jackson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn July 6

(Month)

(Day)

1923
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 6 1923 to July 6 1923

that I last saw him alive on Stillborn 7/6 1923

and that death occurred on the date stated above, at 11:55 AM

The CAUSE OF DEATH* was as follows:

Stillborn July 6 1923

(Duration) Yrs. mos. ds.

Contributory (Secondary) Not Known

(Duration) yrs. mos. ds.

(Signed) Dr. Frank Hall M. D.

July 6 1923 (Address) Eagle

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Dr. Frank Hall

DATE OF BURIAL

7/8 1923

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name or. gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

351-13-0003 113-0003-331 RECEIVED
PLACE OF BIRTH AUG 13 1923
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Bannock
City of Pocatello
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
113457
No. _____ St. _____ Registration District No. _____ State File No. _____
Hospital See Girl Primary Registration District No. 2161 Local Registrar's No. 5077
FULL NAME OF CHILD Not named
(Certificate of no value without full name of child.)
Sex of Child M Twin Triplet or other? _____ and _____ Number in order of birth _____ Legitimate? yes Date of birth 7-13 1923
(Month) (Day) (Year)
What bactericidal solution was used in eyes? ✓
Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____
FATHER FULL NAME Carl Fischer Leaker MOTHER FULL MAIDEN NAME Ellen Clark
RESIDENCE Pocatello Idaho RESIDENCE same
COLOR wht AGE AT LAST BIRTHDAY 22 (Years) COLOR wht AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Salt Lake City, Utah BIRTHPLACE Cedar City, Utah
OCCUPATION Laborer -- Welder OCCUPATION Housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was Stillborn at 7:50 P. M. on the date above stated.
(Signature) [Signature]
(Physician or midwife)
Give names added from a supplemental report.
Address Pocatello Idaho
Filed 8/1 1923 [Signature] Registrar.
Registrar.

RECORDING INFORMATION & REPORT—NEW YORK STATE BIRTH RECORDS
 701 should be taken immediately after a child is born and sent down to town of—N.Y.
 before child is taken to hospital for his care.

PLACE OF BIRTH

STATE OF NEW YORK
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

6781-2 JAN 1913

CERTIFICATE OF BIRTH

113452

No. _____
 Primary Registration District No. _____
 Local Registrar's No. _____

FULL NAME OF CHILD

(Certificate to be filled out by the mother, including present data)
 Sex of child _____
 Date of birth _____
 Time of birth _____
 Place of birth _____
 (To be answered only in event of plural birth)

When fraternal twinning was used to assist

Number of child in this mother, including present birth _____
 Name of child of this mother now living, including present birth _____
 FATHER
 FULL NAME _____
 RESIDENCE _____
 MOTHER
 FULL NAME _____
 RESIDENCE _____

COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at _____
 on the _____ above stated.

(The names added from a supplemental report)
 (When there was no attending physician or midwife, then the father, mother, or other person should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.)

(Signature) _____
 Address _____
 Physician or Midwife _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 13 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
42038
File No. 4114
Registered No.

1. PLACE OF DEATH *Idaho*
County of *Blaine*
City of *Pocatello*
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME *Infant son of Mrs L. F. Lecker*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

16. DATE OF DEATH *July 13 1923*
(Month) (Day) (Year)

6. DATE OF BIRTH *July 13 1923*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 13 1923* to *July 13 1923* that I last saw him *alive on July 13 1923* and that death occurred on the date stated above, at *12:30 P.M.*

7. AGE *None*
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.

The CAUSE OF DEATH* was as follows:
Right Occipital Fracture. Fracture with a laceration of mother's Sacrum of the pelvis, a few seconds in the face death from suffocation.
(Duration) Yrs. mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Contributory (Secondary) (Duration) Yrs. mos. ds.
(Signed) *J. H. May* M. D.
7/14/23 (Address) *Pocatello, Idaho.*

9. BIRTHPLACE *Pocatello*
(State or Country)

10. NAME OF FATHER *L. F. Lecker*

11. BIRTHPLACE OF FATHER *East Lake City*
(State or Country)

12. MAIDEN NAME OF MOTHER *Ella Clark*

13. BIRTHPLACE OF MOTHER *Edwards City Utah*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *L. F. Lecker*
(Address) *Pocatello*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

15. Filed *7-13 1923*

J. H. Young
Local Registrar

19. PLACE OF BURIAL OR REMOVAL *St. Andrew's Church* DATE OF BURIAL *7/14 1923*
20. UNDERTAKER *M. B. Walker* ADDRESS *Pocatello*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

314-1081016-912
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia
City of Burley

RECEIVED
JUL 16 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 113651

No. _____ Registration District No. 117 File No. _____
Hospital _____ State Registration District No. 2196 Registered No. 2584

FULL NAME OF CHILD Stillborn Campbell
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twins Triplet or other?	{ and }	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>June 4</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	-------------------------------	---------	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth. _____ Number of child of this mother now living, including present birth. 0

FATHER
FULL NAME J. J. Campbell
RESIDENCE Burley Ida.
COLOR White AGE AT LAST BIRTHDAY 45 (Years)
BIRTHPLACE Minn.
OCCUPATION Barber

MOTHER
FULL MAIDEN NAME Chester Rasmussen
RESIDENCE Burley
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Idaho
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P. M.
on the date above stated. (Born alive or stillborn)

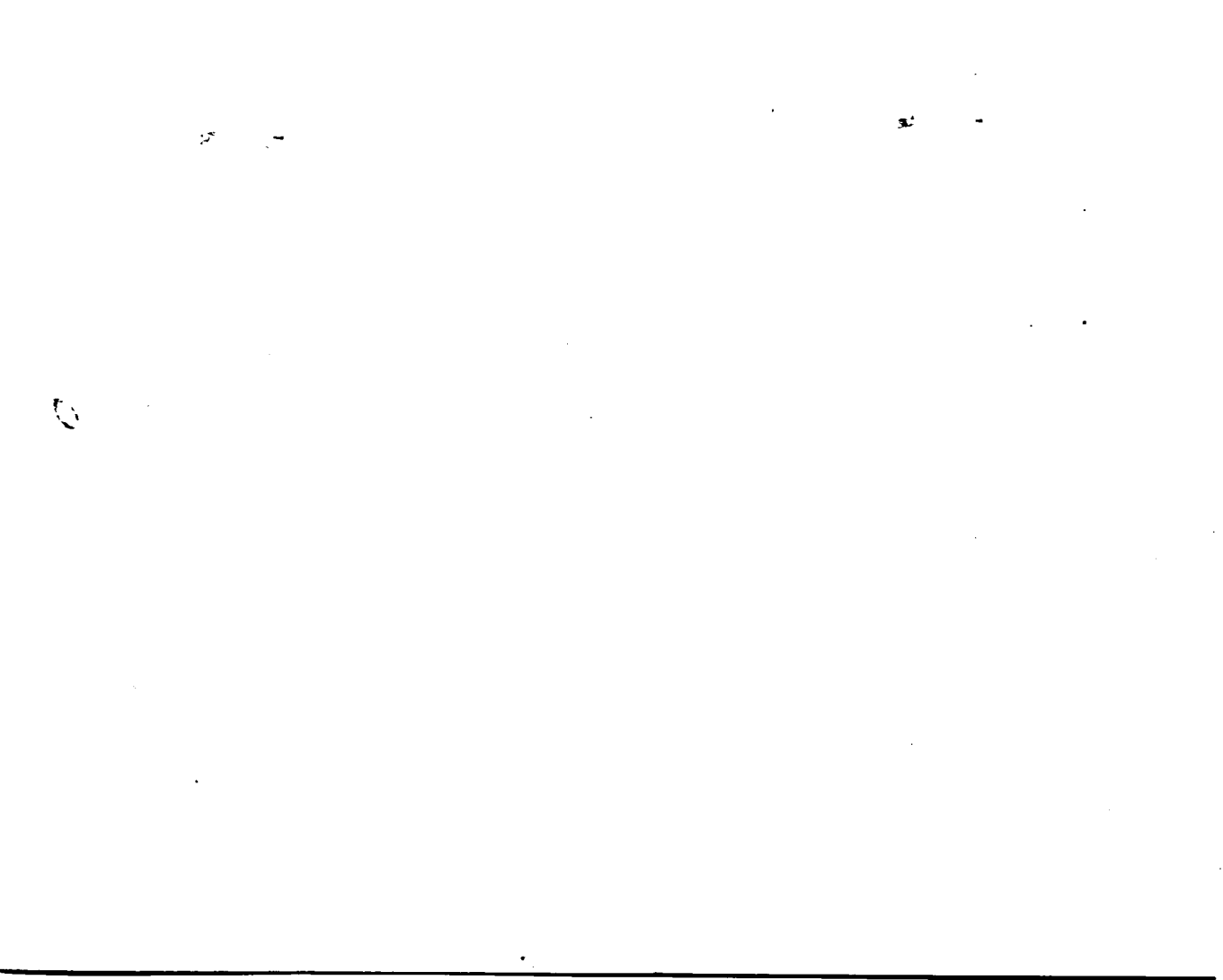
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. C. Patterson
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Burley, Idaho
Filed June 14 1923 Dr. J. C. Patterson
Registrar.



RECEIVED

JUL 16 1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CassiaCity of Burley

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

District No. 117Registration District No. 2196

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 42708Registered No. 662

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Stillborn Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

June 4 1923
(Month) (Day) (Year)

7. AGE

Yrs. # Mos. # ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley, Idaho

10. NAME OF FATHER

J. J. Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Chester Rasmussen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Campbell

(Address)

Burley, Idaho

15.

June 14 1923H. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Patterson M. D.6-14-1923 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley, Idaho

19.....

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

815-227-016-219
PLACE OF BIRTH

RECEIVED

JUL 28 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

113690

County of Cassia BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH
City of Osley
No. _____ St. _____ Registration District No. 120 File No. XXVIII
Hospital _____ Primary Registration District No. 2199 Registered No. 75

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>March 27</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME <u>Frank Hunter</u>	FATHER	FULL MAIDEN NAME <u>Sabelle Barrett</u>	MOTHER
RESIDENCE <u>Osley, Idaho</u>		RESIDENCE <u>Osley, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was dead at 10:45 P. M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

_____, 19____

Registrar.

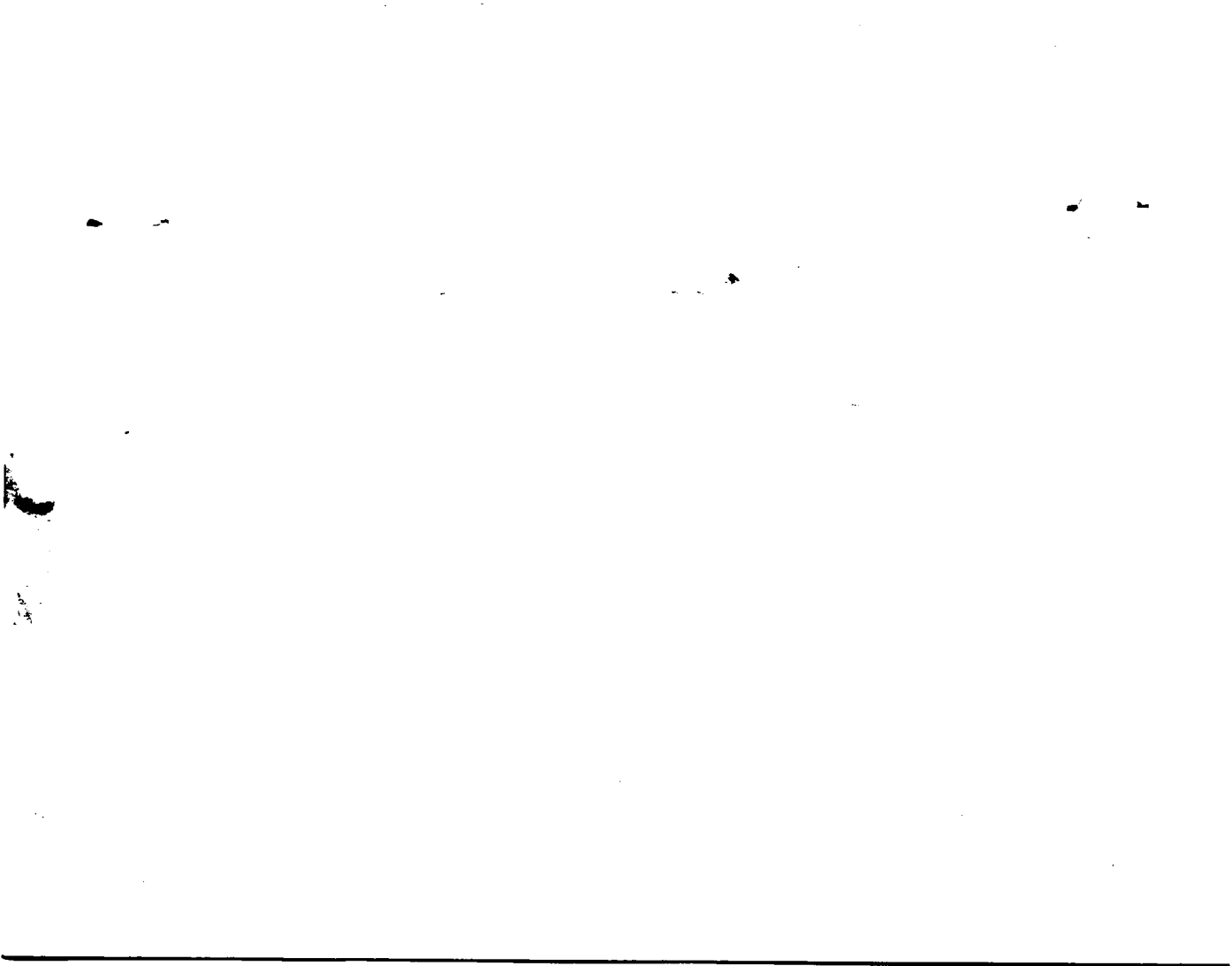
(Signature) _____

(Physician or midwife)

Address _____

Filed June 30 1923 _____

Registrar.



CERTIFICATE OF DEATH

42714

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Carson*City of *Oakley*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. *120*Primary Registration District No. *2199*

(No. St.)

File No. *X 4461*Registered No. *31*

2. FULL NAME

My Name Hunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

March 27 1923
(Month) (Day) (Year)

7. AGE

stat - born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Oakley Idaho.

10. NAME OF FATHER

Frank Hunter

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Isabelle Barrett

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Hunter

(Address)

Oakley Idaho

15.

Filed

*June 30 1923**H. H. Nielson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 27 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw him alive on.....19.....,

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Still-born, due to nephritis in mother

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

H. H. Nielson M. D.*7/30 1923* (Address) *Oakley Idaho*

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Oakley Idaho

DATE OF BURIAL

7/28 1923

20. UNDERTAKER

B. J. Harper

ADDRESS

Oakley Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

389-225-
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Elmore

City of Glenn's Ferry

No. _____ St. _____

Primary Registration District No. 2021

File No. 113746

Hospital _____

Registered No. _____

FULL NAME OF CHILD Unnamed

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and {	Number in order of birth <u>3</u>	Legiti- mate? <u>yes</u>	Date of Birth <u>July 25</u> 19 <u>23</u> (Month) (Day) (Year)
----------------------------	---	-------	---	-----------------------------	---

FULL NAME <u>Lenard Thrope</u>	FATHER
RESIDENCE <u>Glenn's Ferry Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Freight O.S. & R.R. Co</u>	

FULL MAIDEN NAME <u>Mary Sommers</u>	MOTHER
RESIDENCE <u>Glenn's Ferry Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

July 25, 1923 at 3 A. M.
(Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) _____

J. W. Davis
Physician
(Physician or midwife)

Given names added from a supplemental report. _____

Address _____

Filed _____

Glenn's Ferry Idaho

July 30 1923

J. W. Davis
Registrar.

Registrar.



TO BE A C C E P T E D

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 8/13 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

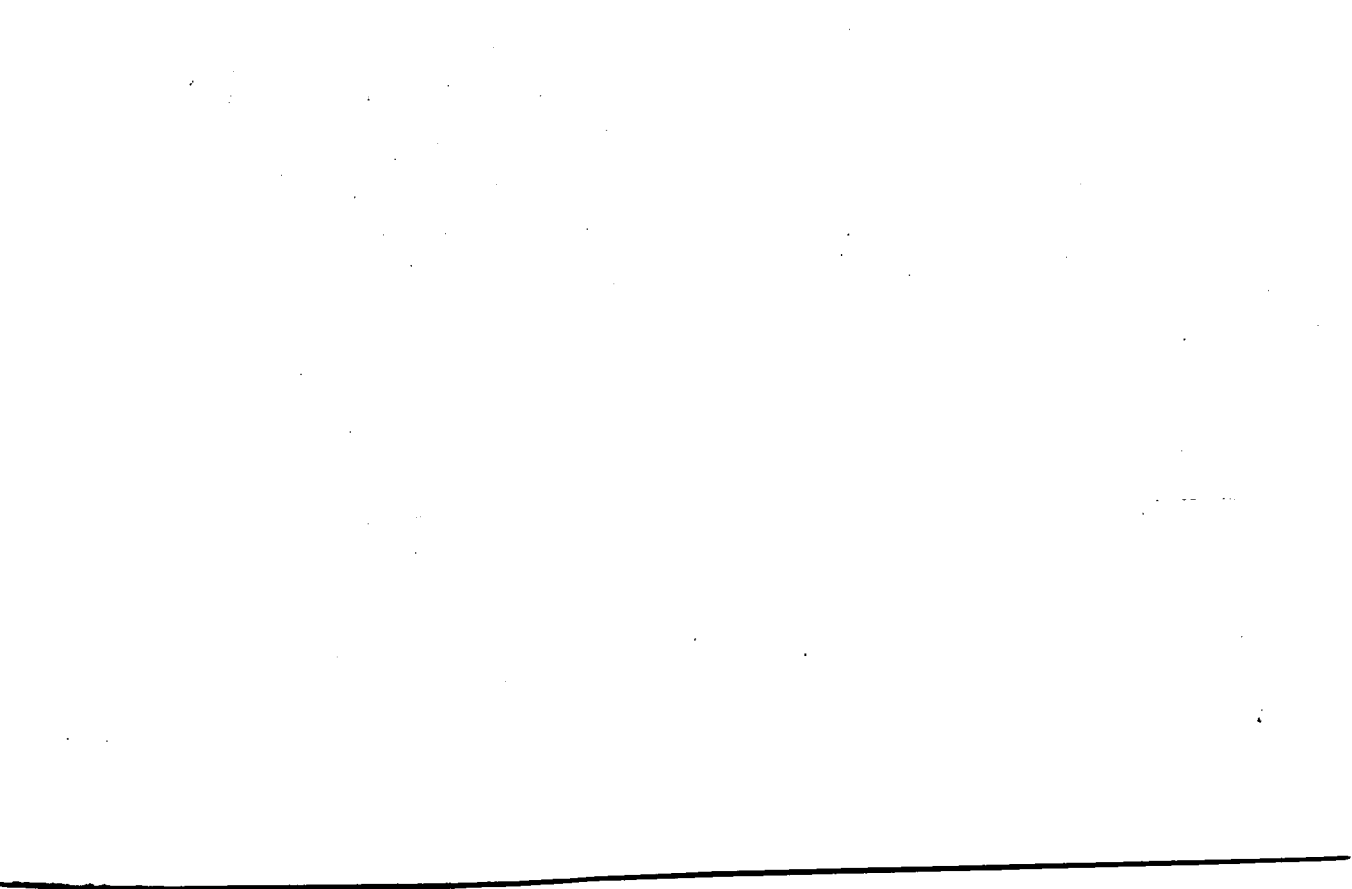
BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY _____	FILE NO. <u>113746</u>
	(ST. _____	DATE OF BIRTH _____
	(COUNTY _____	SEX OF CHILD <u>Female</u>
	FATHER _____	MOTHER _____
		(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Signature of Father or Mother.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-1		RECEIVED AUG 8 1923 BUREAU OF HEALTH		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH. <u>Elmer's Ferry</u>		Registration District No. <u>35</u>		File No. <u>42430</u>		Registered No. _____	
County of <u>Elmer's Ferry</u>		Primary Registration District No. <u>3021</u>		City of <u>Elmer's Ferry</u> (No. _____, St.)		If death occurred in a hospital, institution or camp give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Unusual</u>					
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH <u>153</u>			
3. SEX <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Single</u> (Write the word.)		16. DATE OF DEATH <u>July 26</u> 19 <u>23</u> (Month) (Day) (Year)	
6. DATE OF BIRTH <u>July 25</u> 19 <u>23</u> (Month) (Day) (Year)		7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.		17. I HEREBY CERTIFY, That I attended deceased from <u>July 28</u> 19 <u>23</u> to <u>July 28</u> 19 <u>23</u> that I last saw h. _____ alive on _____ 19 <u>23</u> and that death occurred on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows: <u>Unable to tell, was case of</u> <u>placenta praevia probably</u> <u>lack of nutrition</u> (Duration) _____ yrs. _____ mos. _____ ds.			
8. OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		9. BIRTHPLACE (State or Country) <u>Idaho</u>		Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.			
10. NAME OF FATHER <u>Zimrod Shrope</u>		11. BIRTHPLACE OF FATHER (State or Country) <u>Idaho</u>		(Signed) <u>J. H. Davis</u> M. D. <u>July 26 1923</u> (Address) <u>Elmer's Ferry Idaho</u>			
12. MAIDEN NAME OF MOTHER <u>Mary Summers</u>		13. BIRTHPLACE OF MOTHER (State or Country) <u>Idaho</u>		*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Mary Shrope</u> (Address) <u>Elmer's Ferry Idaho</u>		15. Filed <u>July 26 1923</u> <u>J. H. Davis</u> Local Registrar		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was Disease contracted, _____ If not at place of death? _____ Former or usual residence _____			
19. PLACE OF BURIAL OR REMOVAL <u>Elmer's Ferry Idaho</u>		DATE OF BURIAL <u>Aug. 26 1923</u>		20. UNDERTAKER <u>Zimrod Shrope</u> <u>Elmer's Ferry Idaho</u>			

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

954-1191-023557
PLACE OF BIRTH

IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

AUG 9 1923 CERTIFICATE OF BIRTH

113766

County of Ben

City of Emmett

No. _____ St. _____

Hospital _____

BUREAU OF VITAL STATISTICS

Primary Registration District No. _____

File No. _____

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>-</u> and <u>-</u> (To be answered only in event of plural births)	Number in order of birth <u>-</u>	Legiti- mate? <u>yes</u>	Date of birth <u>7</u> <u>14</u> <u>1923</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Albert D. Lusk
RESIDENCE to go Emmett
COLOR white AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Wyo
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Georgie C. Evans
RESIDENCE Emmett
COLOR white AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Ida
OCCUPATION Homemaker

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at 9 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____

Burton O. Clark

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed 8/7 1923

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

695-223-025-231
PLACE OF BIRTH

RECEIVED

AUG 11 1923

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Idaho

City of Ferdinand

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 105 State File No. 113810

Hospital _____ Primary Registration District No. 2183 Local Registrar's No. 48

FULL NAME OF CHILD Mary Christenia Frei

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>7-23</u> , <u>1923</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>William Frei</u>	FULL MAIDEN NAME	<u>Elizabeth Staab</u>
RESIDENCE	<u>Ferdinand, Idaho.</u>	RESIDENCE	<u>Ferdinand, Idaho.</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>31</u> (Years)	AGE AT LAST BIRTHDAY	<u>20</u> (Years)
BIRTHPLACE	<u>Schwitzerland</u>	BIRTHPLACE	<u>Minnesota</u>
OCCUPATION	<u>farmer</u>	OCCUPATION	<u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~born~~ stillborn at 10:15 P. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____

(Physician or midwife)

Give names added from a supplemental report.

Address Cottonwood, Idaho.

Filed Aug 1 1923 W. F. Over

Registrar.

Registrar.

1-77488 20-100-1-1

CHANGING STRINGS

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 11384

Hospital _____ Primary Registrar _____ District No _____ Local Registrar No _____

TRUE NAME OF CHILD.

(Slide to show the United States map on the wall.)

	to send him	-Hiram Tamm	rooming house at 47rd St.	has written letter to me	to red pen
(see)	(see)	(Hiram)	forwarded to you have in view between the		

...factors of some other nationalities included in it.

[Faint, illegible text at the bottom of the page]

which was suggested by the fact that the water was not at all clear.

934747

RENTON

RESIDENCE

NO. 10

TRA LA SDA
YARHUSIN

RESULTS

TRA: TA 30A
240H1518

БІРТИРА

(27 Nov 91)

SAJAHIB

NOT A CUBO

OCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that the above is a true and correct copy of the original.

When there was no attending physician on duty, the father, mother, etc. should make the return. A religious call is one that minister to the soul and gives of other evidence of life after death.

1. The Bureau of the League of Nations, Geneva, Switzerland, has been notified of the above-mentioned matter.

(01804418)

(continued on inside cover)

... 2000

4419

581

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of IdahoCity of Ferdinand

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Christina Frei

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

July 23 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Wm. G. Frei

11. BIRTHPLACE OF FATHER

(State or Country) Schweizerland

12. MAIDEN NAME OF MOTHER

Elizabeth Staab

13. BIRTHPLACE OF MOTHER

(State or Country) Prussia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Frei

(Address)

Ferdinand Idaho

15.

Filed Aug. 1 1923W. F. Orr

Local Registrar

RECEIVED CERTIFICATE OF DEATH

Registration District No. 105Primary Registration District No. 2183

STATISTICAL

42733

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 8

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn 19_____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19_____, to 19_____,

that I last saw him alive on 19_____,

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Unknown
Labor 11 hrs. - 1st baby - parents apparently healthy - Full term - No evident cause!

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wesley F. Orr M. D.
7/23 1923 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ferdinand

DATE OF BURIAL

7/24 1923

20. ADDRESS

Father Michael Ferdinand

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

866 227-025-259
PLACE OF BIRTH

RECEIVED

AUG 11 1923

BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

113814

County of Idaho

City of Butte

No. _____ St. _____

Registration District No. 106

File No. _____

Hospital _____

Primary Registration District No. 2184

Registered No. 22

FULL NAME OF CHILD Edward & Mos Fritus -

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u> { and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>July 21 1923</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 5 Number of child of this mother now living, including present birth... 4

FULL NAME <u>Lawrence Howard</u>	FATHER
RESIDENCE <u>Butte</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Laborer</u>	

FULL MAIDEN NAME <u>Stella Berthoff</u>	MOTHER
RESIDENCE <u>Butte</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Wash.</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:20 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. M. Verburkues.
Physician
(Physician or midwife)

Give names added from a supplemental report.

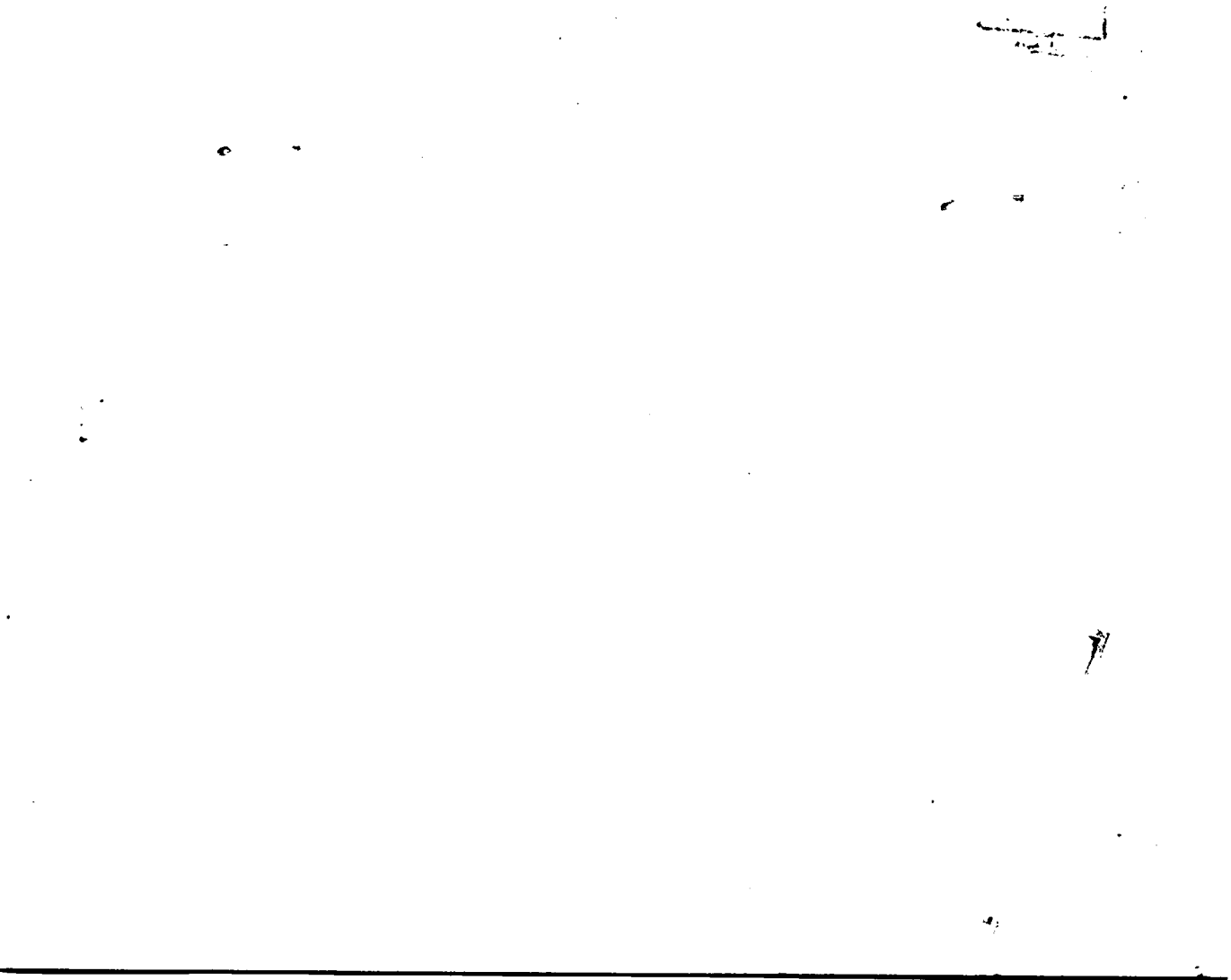
Address

Butte, Idaho

Filed

Aug 1 1923 J. M. Verburkues
Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*
City of *Stites*BUREAU OF VITAL
STATISTICS

AUG 11 1923

Registration District No. *106*Primary Registration District No. *2184*File No. *12136*Registered No. *1424*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stella Bertholf 6 1/2 months

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 2/ 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Lawrence Howard

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho Washington

12. MAIDEN NAME OF MOTHER

Stella Bertholf

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs J. R. Thompson*(Address) *Stites - Idaho*

15.

Filed *July 23* 1923*J. M. Vanhook*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 2/ 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature birth - 6 1/2 months

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Vanhook M. D.
July 23, 1923 (Address) *Kootenai - Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

State Cemetery

DATE OF BURIAL

July 23, 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

493-226-028-231
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai
City of Rathdrum
No. _____ St. _____

AUG 11 1923
BUREAU OF
Registration District No. _____

CERTIFICATE OF BIRTH

File No. 113835

Hospital _____ Primary Registration District No. 1057 Registered No. 1606

FULL NAME OF CHILD (unnamed, stillborn) Miller
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>July 26</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	-----------	--------------------------------	------------------------	---

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 7

FULL NAME Charles N. Miller FATHER

FULL MAIDEN NAME Amelia Black MOTHER

RESIDENCE Rathdrum, Id. R 2.

RESIDENCE Rathdrum, Id. R 2.

COLOR white AGE AT LAST BIRTHDAY 41
(Years)

COLOR white AGE AT LAST BIRTHDAY 35
(Years)

BIRTHPLACE Wis.

BIRTHPLACE Id.

OCCUPATION farmer

OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 4:30 P. M.
on the date above stated. (Born alive or stillborn)

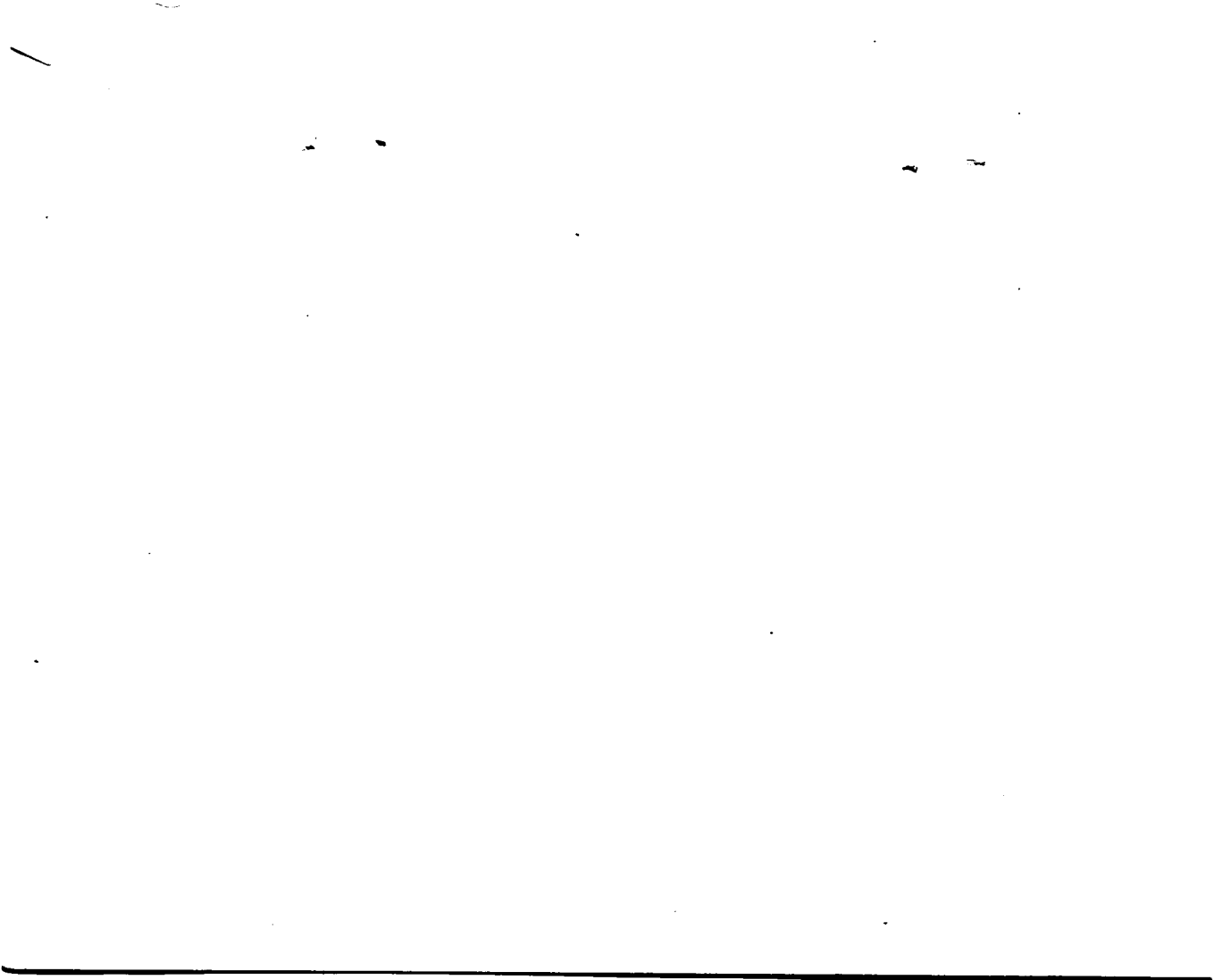
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Frank H. Hays
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Rathdrum, Id.
Filed Aug 4, 1923 W. D. Drennon
Registrar.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Portland*City of *Rathdrum*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(unnamed) Miller

CERTIFICATE OF DEATH

RECEIVED
AUG 14 1923
BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

30

1001

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

July 26 1923
(Month) (Day) (Year)

7. AGE

stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Charles W. Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Annabel Block

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles W. Miller

(Address)

R. Rathdrum, Ida. R. 1.

15.

Filed

*Aug 9 1923**D. D. Brennan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 26 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased *was**stillborn* 19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Congenital enlargement of liver 3 times normal size

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Frank Henry M. D.**7/26 23* (Address) *Rathdrum, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rathdrum Idaho**7/26 1923*

20. UNDERTAKER

ADDRESS

*E. E. Bready**Rathdrum*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

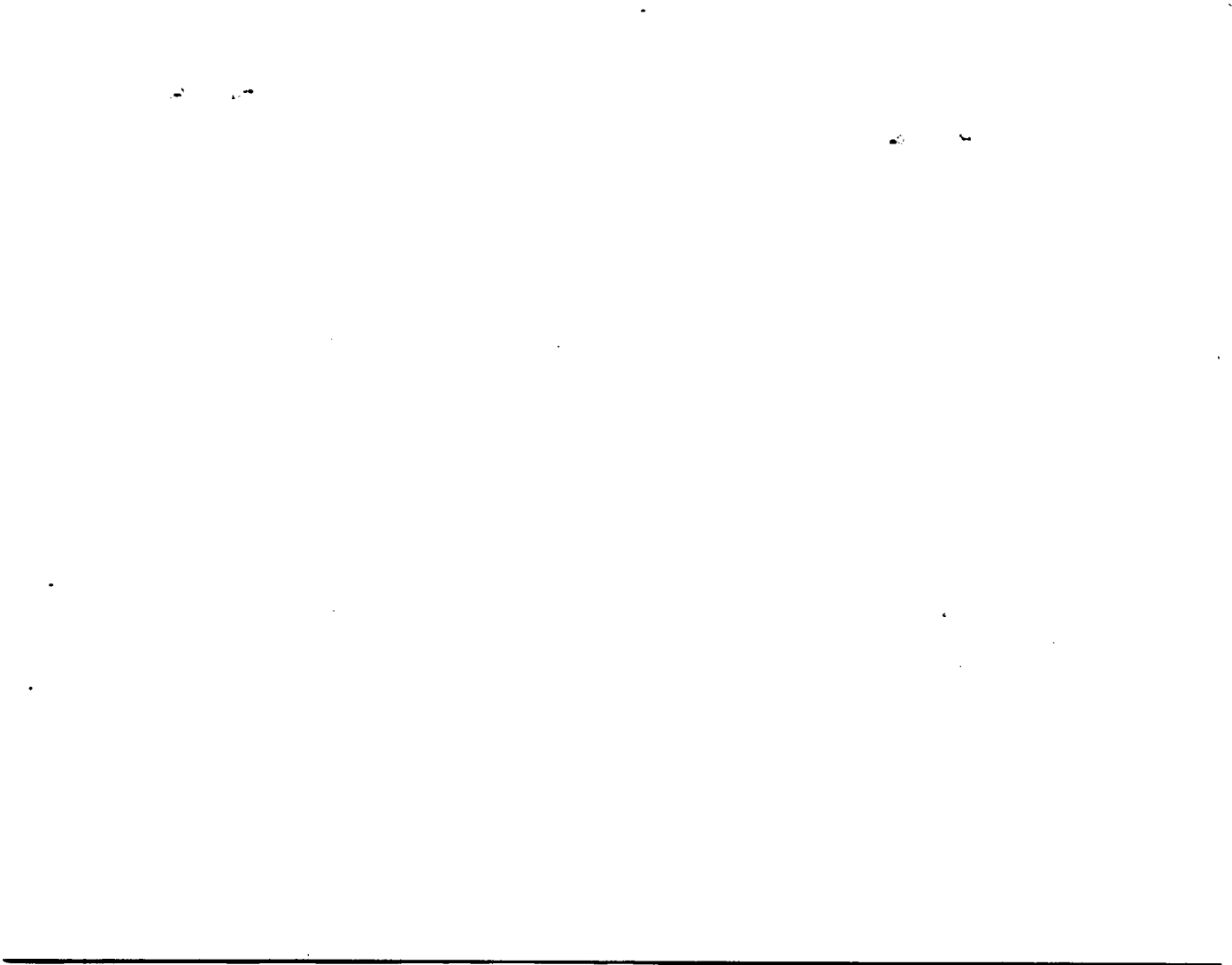
STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

295-106, 042-395
PLACE OF BIRTH
Twin Falls, Idaho
JUL 24 1923
RECEIVED
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Kimberly, Idaho
CITY OF
REGISTRATION DISTRICT NO. 36
FILE NO. 113954
HOSPITAL home
PRIMARY REGISTRATION DISTRICT NO.
REGISTERED NO. 29
FULL NAME OF CHILD Jasper Linsey King
(Certificate of no value without full name of child.)
SEX OF CHILD male
Twin Triplet or other? { and } Number in order of birth
(To be answered only in event of plural births)
LEGITIMATE? yes
DATE OF BIRTH June 6, 1923
(Month) (Day) (Year)
What bacteriocidal solution was used in eyes? neosilvol
Number of child of this mother, including present birth 1
Number of child of this mother now living, including present birth 0
FATHER
FULL NAME Jasper King
RESIDENCE Kimberly, Idaho
COLOR W
AGE AT LAST BIRTHDAY 29
(Years)
BIRTHPLACE Mo.
OCCUPATION Elevator foreman
MOTHER
FULL MAIDEN NAME Hazel Linesey
RESIDENCE Kimberly, Idaho
COLOR W
AGE AT LAST BIRTHDAY 24
(Years)
BIRTHPLACE Nebr.
OCCUPATION Hw.
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
I hereby certify that I attended the birth of this child, who was Stillborn at 9 P. M.
on the date above stated. (Born alive or stillborn)
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }
(Signature) J. W. Davis
physician (Physician or midwife)
Give names added from a supplemental report.
Address Kimberly, Idaho
Filed June 10, 1923
Registrar. J. W. Davis Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shwinn Falls*City of *Kimberly*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. *36*County Registration District No. *1623*

BUREAU OF VITAL

STATISTICS

File No. *42813*Registered No. *10*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Jack Linessy King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 6

(Month)

1923
(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Jasper Linessy King

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Mayle Linessy

13. BIRTHPLACE OF MOTHER

(State or Country)

Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jasper King
Kimberly, Id.

15.

Filed

*June 6 1923**M. W. Davis*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6

(Month)

(Day)

1923
(Year)17. I HEREBY CERTIFY, That I attended deceased from *June 6 1923* to *June 6 1923* that I last saw him alive on *June 6 1923* and that death occurred on the date stated above, at *about 8:30 P.M.*

The CAUSE OF DEATH was as follows:

*Stillbirth**asphyxiated at birth*

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. W. Davis

M. D.

4/6 1923

(Address)

Kimberly, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Shwinn Falls, Ida**June 7 1923*

20. UNDERTAKER

ADDRESS

*C. P. Grossman**Shwinn Falls*
Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

296-207,042-381
PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls
City of Twin Falls

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 37 File No. 113979
Hospital County Hospital Primary Registration District No. 1085 Registered No. _____
FULL NAME OF CHILD Edna Brown

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	<u>Twin</u> <u>yes</u> { and { <u>Number</u> <u>1</u> <u>in order</u> <u>of birth</u>	Legitimate? <u>yes</u>	Date of birth <u>July 7</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Clifford W. Brown</u>	FULL MAIDEN NAME	<u>Ella Chaney</u>
RESIDENCE	<u>Twin Falls</u>	RESIDENCE	<u>Twin Falls</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>26</u> (Years)	AGE AT LAST BIRTHDAY	<u>20</u> (Years)
BIRTHPLACE	<u>Iowa</u>	BIRTHPLACE	<u>Montevista Colo</u>
OCCUPATION	<u>mechanic</u>	OCCUPATION	<u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 am on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) John J. Coughlin

Phys.

(Physician or midwife)

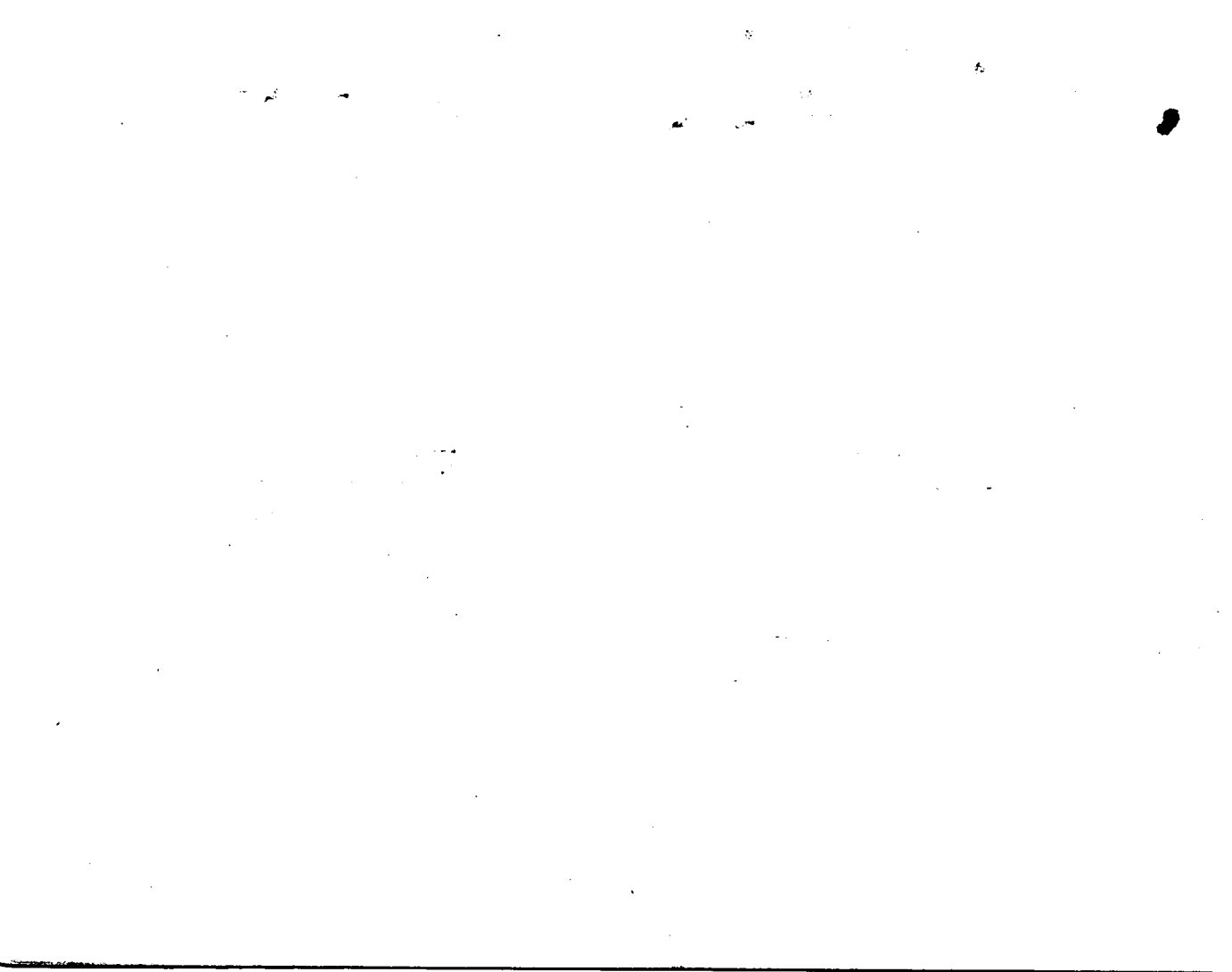
Give names added from a supplemental report.

Address Twin Falls

Filed Aug. 1 - 1923 John J. Coughlin

Registrar.

Registrar.



RECEIVED
AUG 1 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42300

Registered No.

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37.
City of Twin Falls Primary Registration District No. 1085.
State of Idaho City-General Hospital, (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Brown Twin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female White (Baby)

6. DATE OF BIRTH

July 2 1923
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Baby

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Clifford W. Brown

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Ella J Chaney

13. BIRTHPLACE OF MOTHER

(State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clifford W Brown
(Address) Twin Falls, Idaho

15.

Filed AUG 1 1923

John T. Cougle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 - 2 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

V. L. 1923 to 7-2 23

that I last saw him alive on 7-2 1923

and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) ? Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

John T. Cougle M. D.
7-3 1923 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL.

Twin Falls Idaho July 3 1923

20. UNDERTAKER

J. G. Gorman Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. H.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

253-115,042-265
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Twin Falls

City of Buhl

No. St.

Hospital.....

RECEIVED
AUG 11 1923
BUREAU OF VITAL

Registration District No. 34

Primary Registration District No. 287

CERTIFICATE OF BIRTH

State File No. 113989

FULL NAME OF CHILD.....

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>7-15-</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Chas. Wesley Secor

RESIDENCE Buhl

COLOR wht.

AGE AT LAST
BIRTHDAY 34
(Years)

BIRTHPLACE Canada

OCCUPATION

MOTHER
FULL MAIDEN NAME Myrtle Lova

RESIDENCE Buhl

COLOR wht

AGE AT LAST
BIRTHDAY 35
(Years)

BIRTHPLACE Kans.

OCCUPATION H. Secor

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 9:30 a. m.
on the date above stated. Stillborn

*When there was no attending physi-
cian or midwife, then the father, house-
holder, etc., should make this return.
{ A stillborn child is one that neither
breathes nor shows other evidence of
life after birth.

(Signature) Geo. Jennings, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Buhl, Ida.

Filed JUL 31 1923

Registrar.

Registrar.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42795

1. PLACE OF DEATH

County of Latah Registration District No. 39
City of Castleford Union District No. 2087
State of Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Secord

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 15 23
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Castleford

10. NAME OF FATHER

C. W. Secord

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Effie Sofa

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. W. Secord

(Address)

Castleford Ida

15.

Filed 7-16 1923

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-15-1923 to 7-15-1923

that I last saw him alive on 7-15-1923

and that death occurred on the date stated above, at 101 M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Dr. Jennings M. D.

7-15-1923 (Address) Booth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Booth Ida July 16 1923

20. UNDERTAKER

ADDRESS

J. H. Murphy Booth Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 693-102 005-249
COUNTY OF Blaine
CITY OF Blackfoot
No. _____ St. _____
HOSPITAL _____
FULL NAME OF CHILD Unnamed Male

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

SEP 8 1923

CERTIFICATE OF BIRTH

State-File No. 11 4153

BUREAU OF VITAL STATISTICS

Primary Registration District No. 2194 Local Registrar's No. 290

(Certificate of no value without full name of child.)

Sex of Child Male Twin Triplet or other? _____ and Number in order of birth _____ Legitimate? Yes Date of birth Aug 3 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME <u>Samuel D. Malcox</u>	FULL NAME <u>Carrie Smith</u>	FULL NAME	FULL NAME
RESIDENCE <u>Blackfoot Idaho</u>	RESIDENCE <u>Id</u>	RESIDENCE	RESIDENCE
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>42</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>39</u> (Years)	COLOR	COLOR
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Utah</u>	BIRTHPLACE	BIRTHPLACE
OCCUPATION <u>Common Laborer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was born alive at Blackfoot on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. E. Latimer M.D.

Give names added from a supplemental report.

(Physician or midwife) Address Blackfoot Idaho

Filed Sept 4 1923 Registrar W. E. Latimer

Registrar.

THIS FORM IS TO BE FILLED OUT BY THE ATTENDING PHYSICIAN OR MIDWIFE AT THE TIME OF BIRTH AND MUST BE RETURNED TO THE HEALTH DEPARTMENT WITHIN 10 DAYS OF THE DATE OF BIRTH. IT IS THE DUTY OF THE ATTENDING PHYSICIAN OR MIDWIFE TO FURNISH THE INFORMATION REQUIRED HEREON.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

PLACE OF BIRTH

FULL NAME OF CHILD

Sex of Child

Living or other?

and in other

of birth

(To be answered only in event of plural births)

Month

Day of birth

(Day)

(Year)

If not hospitalized mention was made in report

Name of mother including present name

FATHER

FULL NAME

FULL NAME

MOTHER

Name of child of this mother now living, including present birth

RESIDENCE

RESIDENCE

COLOR

COLOR

AGE AT LAST BIRTHDAY

AGE AT LAST BIRTHDAY

(Years)

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at the date above stated.

*When there was no attending physician or midwife, then the father, husband, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Give names added from a supplemental report)

102

REGISTERED

REGISTERED

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
1923COUNTY OF
BLACKFOOT
STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filled

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Stillborn - premature 5 1/2 months - mother overworked by this garden

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine

AUG 31 1923

City of Carey

BUREAU OF VITAL

CERTIFICATE OF BIRTH 114179

No. 534-112007-366 St.Registration District No. 57State File No. 43

Hospital

Primary Registration District No. 2025 Local Registrar's No. 43

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

}

and {

Number
in order
of birthLegiti-
mate?yesDate of
birth6-121923

(Month) (Day) (Year)

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 5Number of child of this mother now living, including present birth 4FULL
NAME

FATHER

A Claver E. Eldredge

RESIDENCE

Carey Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY40
(Years)

BIRTHPLACE

Utah

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Edith S Cook

RESIDENCE

Carey

COLOR

WhiteAGE AT LAST
BIRTHDAY39
(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ~~born alive~~ at 10:50 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Houston E. Snyder

(Physician or midwife)

Address

Carey Idaho

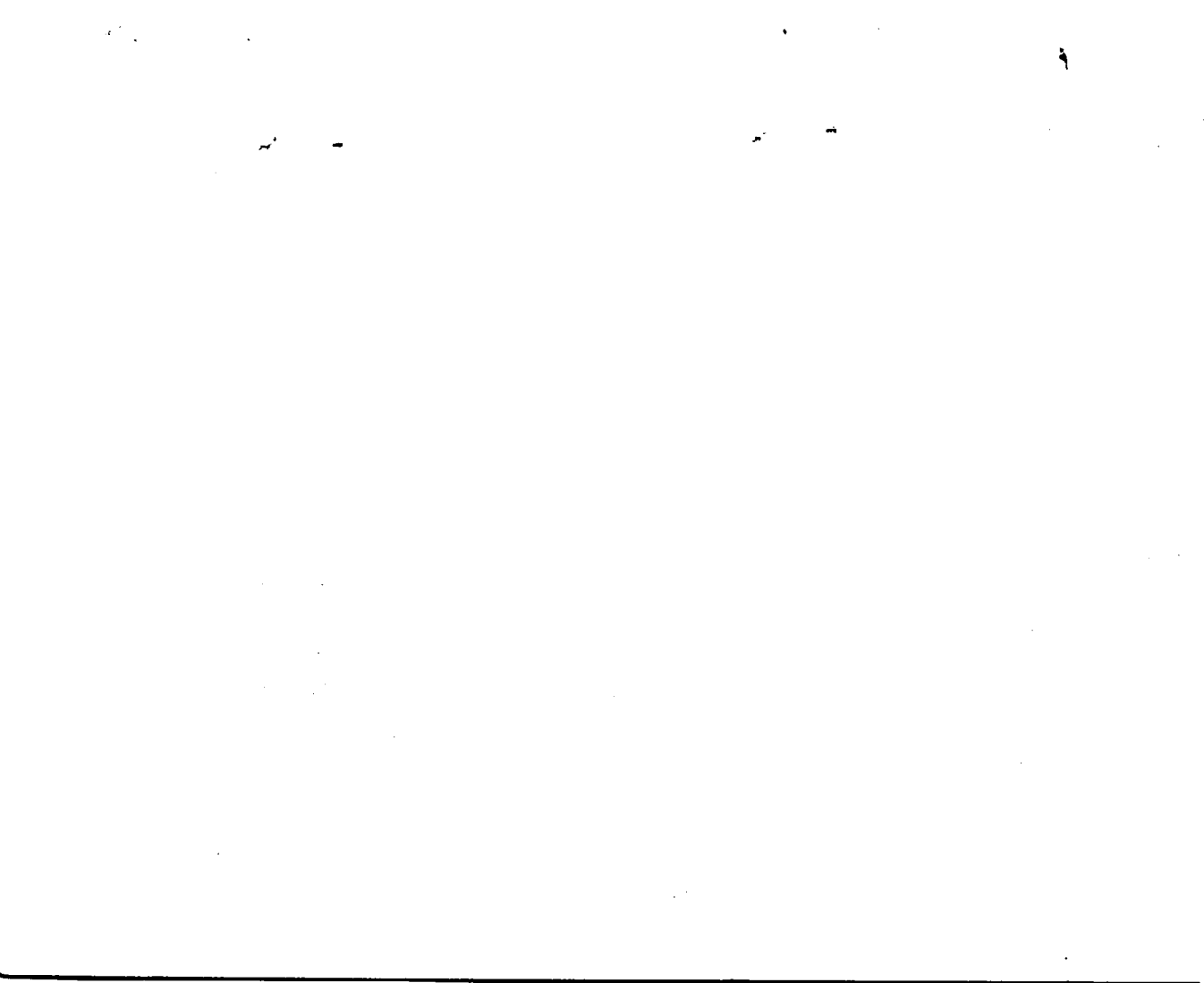
Filed

8-231923Robert H. Wright

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



RECEIVED

AUG 31 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

42878

1. PLACE OF DEATH

County of BlaineCity of CareyRegistration District No. 57Primary Registration District No. 2025

(No. _____ St.)

File No. _____

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

6 12 1923
(Month) (Day) (Year)

7. AGE

Skyl Barn
Yrs. Mos. da.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Blaine Co. Idaho

10. NAME OF FATHER

A Clarence Eldredge

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Edith L Cook

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Houston E Snyder

(Address)

Carey Idaho

15.

Filed 8/231923R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 12 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 6-12 1923 to 6-12 1923

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

I don't know.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Houston E Snyder M. D.

19 _____

(Address)

Carey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carey Ida6-13 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of FranklinCity of PrestonNo. 369127021-235

RECEIVED
SEP 10 1923
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

State File No. 114388

Hospital

Primary Registration District No. 2119Local Registrar's No. 187

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>yes</u>	Legitimate? <u>yes</u>	Date of birth (Month) <u>Aug</u> (Day) <u>27</u> (Year) <u>1923</u>
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? Ag. 2070Number of child of this mother, including present birth 8Number of child of this mother now living, including present birth 5

FULL NAME

FATHER

L. Louis Corbridge

RESIDENCE

Preston, Ida.COLOR WAGE AT LAST BIRTHDAY 40 (Years)BIRTHPLACE IdahoOCCUPATION Farming

FULL MAIDEN NAME

MOTHER

Effie Stephens

RESIDENCE

Preston, Ida.COLOR WAGE AT LAST BIRTHDAY 38 (Years)BIRTHPLACE IdahoOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 159 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) U. R. Culler

(Physician or midwife)

Give names added from a supplemental report.

Address Preston, IdahoFiled Sept 7 1923Mrs. Ida Lyppe

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

2

J

-

J

-

RECEIVED
SEP 10 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of PrestonDistrict No. 27Primary Registration District No. 2119

(No. St.)

File No. 42924Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn infant of S. Loin Corbridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Aug 27 1923
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 da.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. ✓
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

S. Loin Corbridge

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Effie Stephens

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ✓

(Address) ✓

15.

Filed Sept 7 1923Mrs Ida Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 27 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1923, to Aug 27, 1923, that I last saw him alive on not at all, 1923, and that death occurred on the date stated above, at 2:15 M. The CAUSE OF DEATH* was as follows:
Purpura separation of placenta
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) F. R. Gentry M. D.
.....19..... (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston, Ida. Aug 28 1923
20. UNDERTAKER ✓ ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

269 107 070-255
PLACE OF BIRTH

Country Tremont
City Anthony
No. _____ St. _____

RECEIVED DEPT. OF PUBLIC WELFARE
STATISTICS
SEP 3 1923
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

S

BIRTH 114402

Hospital _____ Primary Registration District No. 2177 Local Registrar's No. 124

FULL NAME OF CHILD Barreton
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>yes</u>	Date of birth <u>Aug 7</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	------------------------------	--	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>7</u>		Number of child of this mother now living, including present birth <u>6</u>	
FULL NAME <u>FATHER</u> <u>P. C. Barreton</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Anne E. Severney</u>	FULL NAME <u>FATHER</u> <u>P. C. Barreton</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Anne E. Severney</u>
RESIDENCE <u>Anthony, Idaho</u>	RESIDENCE <u>Anthony, Idaho</u>	RESIDENCE <u>Anthony, Idaho</u>	RESIDENCE <u>Anthony, Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Utah</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:30 p M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Wm. D. Gearey
(Physician or midwife)

Give names added from a supplemental report. _____, 192____
Address Anthony, Idaho
Filed 9/1 1923 Wm. D. Gearey
Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **42926**
Registered No. **44**

1. PLACE OF DEATH

County of **Fremont**
City of **St. Anthony**

Registration District No. **99**Tributary Registration District No. **2177**

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME **Stillborn**

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

August 7th, 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) **St. Anthony, Idaho.**10. NAME OF
FATHER**P. C. Rasmussen**11. BIRTHPLACE
OF FATHER(State or Country) **Utah**12. MAIDEN NAME
OF MOTHER**Anna Cholie Swensen**13. BIRTHPLACE
OF MOTHER(State or Country) **Utah.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. C. Rasmussen(Address) **St. Anthony, Idaho**

15.

Filed

Aug. 7 1923

W. H. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 7 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 19. to Aug 8 1923that I last saw him alive on **19. _____**and that death occurred on the date stated above, at **_____ M.**

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

James J. Geary M. D.
8/8 1923 (Address) **St. Anthony, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Anthony

DATE OF BURIAL

Aug. 19 1923

20. UNDERTAKER

None

ADDRESS

St.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

225-105023-493
PLACE OF BIRTH

RECEIVED

SEP 8 1923

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of IdahoBUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

S
114437City of EmmettRegistration District No. 6

File No. _____

No. _____ St. _____

Primary Registration District No. _____

Registered No. _____

Hospital _____

FULL NAME OF CHILD

Herbert Allen SkeltonSex of
ChildMaleTwin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?YesDate of
BirthAug 51923

(To be answered only in event of plural births)

(Month) (Day) (Year)

FULL
NAMEAlfred Chamcy Skelton

FATHER

FULL
MAIDEN
NAMEBessie Cordelia Miles

MOTHER

RESIDENCE

Emmett Ida

RESIDENCE

Emmett Ida

COLOR

WhiteAGE AT LAST
BIRTHDAY33

COLOR

WhiteAGE AT LAST
BIRTHDAY32

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Saw mill labor

OCCUPATION

House wifeNumber of child of this mother, including present birth 1Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.Still

(Born alive or stillborn)

at 2-30 a.m.*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. L. Reynolds

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Emmett

Filed

8/71923J. L. Reynolds
Registrar

Registrar

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 9/12 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Emmett FILE NO. 104457
 (ST. Idaho DATE OF BIRTH Aug 5th 1923
 (COUNTY Gern SEX OF CHILD Male

FATHER Alfred Chauncy Skelton MOTHER Bessie Cordealia Miles
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Hubert Allen Skelton

Alfred C. Skelton

Signature of Father or Mother.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of Gum
City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hubert Allen Skelton

CERTIFICATE OF DEATH.

RECEIVED
SEP 8 1923
BUREAU OF VITAL STATISTICS

Registration District No. _____
Registration District No. 6 _____
(No. _____) _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 42932
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MA 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

Aug 5 23
(Month) (Day) (Year)

7. AGE

Still born

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country).

Emmett Ida

10. NAME OF FATHER

Alfred Skelton

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Bessie Cordealis Miles

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alfred C Skelton

(Address)

Emmett Ida

15.

Filed

8/7 23

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 5 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 test birth 191

that I last saw him not at all 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

death in delivery. Due to contracted pelvis in mother.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) J. L. Reynolds M. D.

8/7 1923 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....Mos.....Days In the State.....Yrs.....Mos.....Days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette Ida

DATE OF BURIAL

8/6 1923

20. UNDERTAKER

none

ADDRESS

✓

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

362-226-028 554
362-126-028 554
PLACE OF BIRTH

RECEIVED
AUG 22 1923

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V, S. No. 11-C-25m-7-21-19

County of Shoshone

City of L. Lake

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 45

File No. _____

S114533 A

No. _____ St. _____

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD Twins (premature) not named

Sex of Child <u>1 male</u> <u>1 fem.</u>	Twin <u>Yes</u> Triplet <u>No</u> or other? <u>No</u> (To be answered only in event of plural births)	and {	Number <u>twins</u> in order <u>1</u> of birth <u>1st</u>	Legiti <u>yes</u> mate? <u>yes</u>	Date of Birth <u>Jan 26</u> (Month) (Day) (Year) <u>1923</u>
---	--	-------	---	---------------------------------------	---

FATHER
FULL NAME Henry W. Cohl
RESIDENCE Spent Luke Id
COLOR wh AGE AT LAST BIRTHDAY 34
(Years)
BIRTHPLACE North Carolina
OCCUPATION Machinist
What bactericidal solution was used in eyes? Arg Agnos 1%

MOTHER
FULL MAIDEN NAME Kathie M. Neubauer
RESIDENCE Sp 1
COLOR wh AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Germany
OCCUPATION _____

Number of child of this mother, including present birth _____ Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was male stillborn female, at 4:15 A M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Earl J. Ponder, M.D.

(Physician or midwife)

Given names added from a supplemental report.

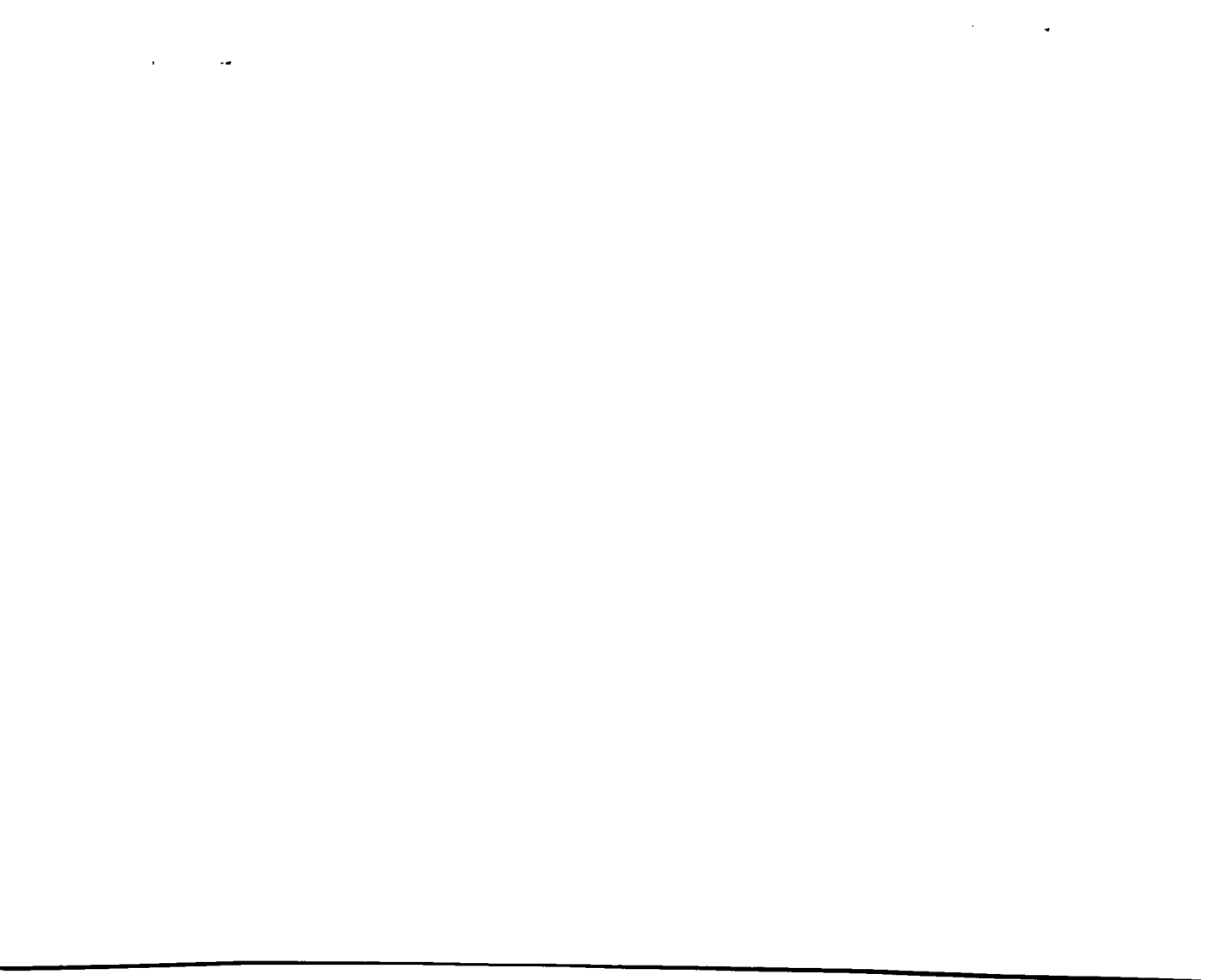
19 _____

Address _____

Filed 2/2 19 23 Shoshone

Registrar

Registrar



THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form-V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **42952**

RECEIVED
1923
BUREAU OF VITAL STATISTICS
1. PLACE OF DEATH. Registration District No. _____
County of Kootenai Primary Registration District No. _____
City of Spirit Lake _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Coble

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. infant
(Write the word.)

6. DATE OF BIRTH Jan. 24 1923
(Month) (Day) (Year)

7. AGE still born IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE Kootenai Co. Id.
(State or Country)

10. NAME OF FATHER Henry Coble

11. BIRTHPLACE OF FATHER North Carolina
(State or Country)

12. MAIDEN NAME OF MOTHER Hattie Neubauer

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. S. Prindle M.D.
(Address) Spirit Lake

15. Filed 1/27 1923 Hawick
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 26 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw him _____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Still Born

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Signed) E. S. Prindle M. D.
Jan 26 1923 (Address) Spirit Lake Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL E. S. C DATE OF BURIAL Jan 27 1923
20. UNDERTAKER Green ADDRESS _____

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

595 225029869

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah
City of Moscow
No. 722 Se. Main St. District No. 101 File No. 114612
Hospital Chas. G. Gutzman Primary Registration District No. 1011 Registered No. 120
FULL NAME OF CHILD Barbara Jean Vincent

(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? } and } Number in order of birth 1 Legitimate? Yes Date of birth. July 25 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth. 4 Number of child of this mother now living, including present birth. 3

FATHER		MOTHER	
FULL NAME	<u>Clarence C. Vincent</u>	FULL MAIDEN NAME	<u>Alice Odalite Horning</u>
RESIDENCE	<u>Moscow, Idaho</u>	RESIDENCE	<u>Moscow, Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>39</u> (Years)	AGE AT LAST BIRTHDAY	<u>40</u> (Years)
BIRTHPLACE	<u>Oregon</u>	BIRTHPLACE	<u>Oregon</u>
OCCUPATION	<u>Prof. of Horticulture</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

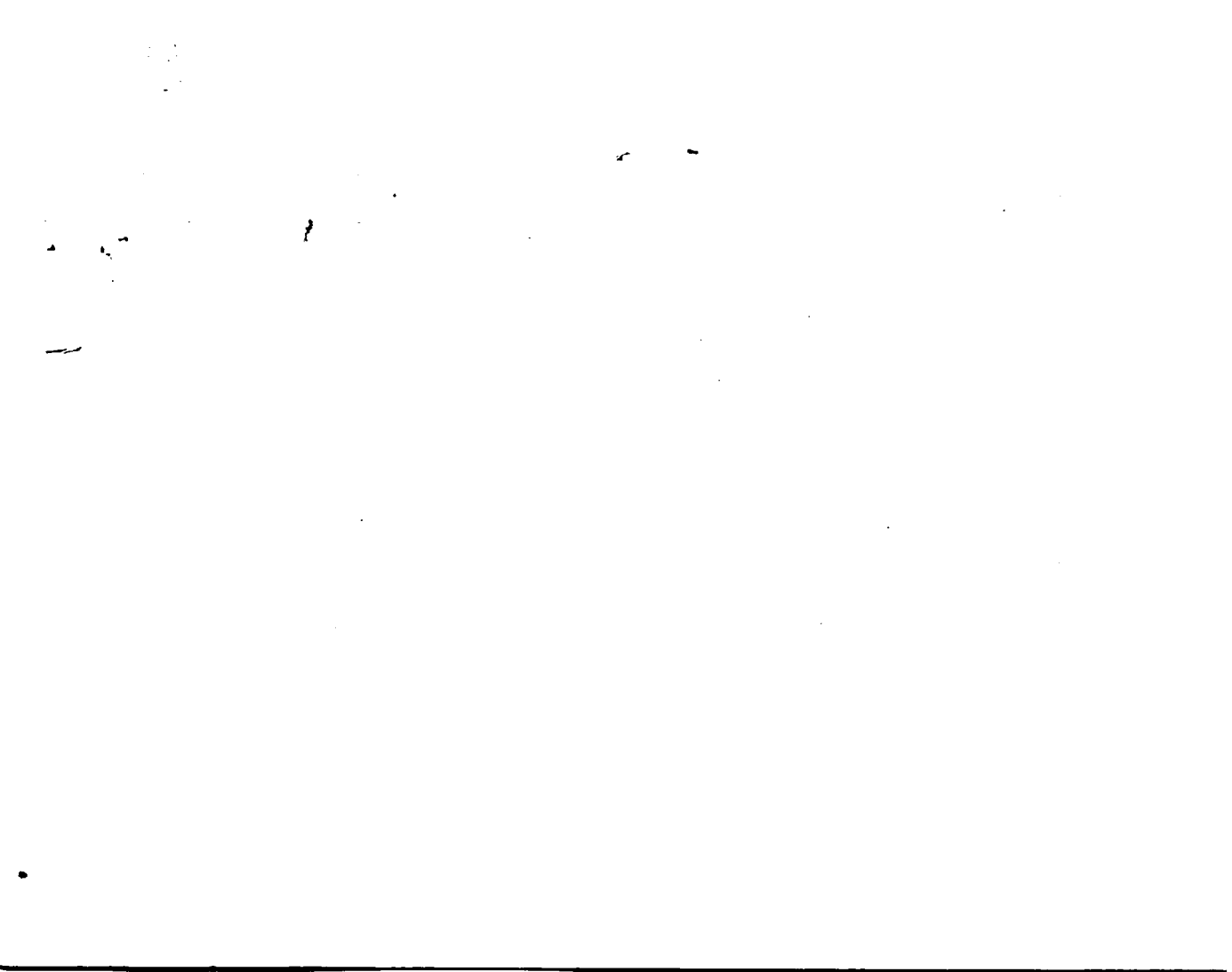
I hereby certify that I attended the birth of this child, who was.....
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Chas. G. Gutzman at Milltown 7:53 A. M.
(Born alive or stillborn)
Physician
(Physician or midwife)

Address Moscow, Idaho
Filed Aug 16 1923 MS Kearthers
Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of LatahCity of Moscow

If death occurs away from usual residence, give facts for under special information.

Registration District No. 61Primary Registration District No. 1011(No. Christman's Hospital (St.))State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 57100Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barbara Vincent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single6. DATE OF BIRTH July 25 1923 (Write the word.)7. AGE Stillborn IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Moscow, Ida.

10. NAME OF FATHER

C. C. Vincent

11. BIRTHPLACE OF FATHER

(State or Country) Oregon

12. MAIDEN NAME OF MOTHER

Odahite Koning

13. BIRTHPLACE OF MOTHER

(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. C. Vincent(Address) Moscow, Ida.15. Filed July 25 1923 M. H. Harithers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 25 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her Stillborn July 25 1923 alive on July 25 1923and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn - Premature
6 1/2 months

(Duration) yrs. mos. ds.
Contributory (Secondary) Probably latently implanted placenta praevia.
(Duration) yrs. mos. ds.

(Signed) Chas. L. Gutman M. D.7/25/1923 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow July 25 1923

20. UNDERTAKER

K. R. Sturt Moscow

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH
719-123 031-144
Lewis

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of _____
City of Winchester, Star Route
No. _____ St. _____
Hospital _____
Primary Registration District No. 2129
Stillborn
Registration District No. 50
File No. 114639
Registered No. 45

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of male Child	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate Yes Yes	Date of birth. _____ 1923 (Month) Aug (Day) 23 (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 0

FATHER		MOTHER	
FULL NAME	Thomas Elmo Garrett	FULL MAIDEN NAME	Florence Willicent Judd
RESIDENCE	Winchester, Star Route	RESIDENCE	Winchester, Star Route
COLOR	white	COLOR	white
AGE AT LAST BIRTHDAY	31 (Years)	AGE AT LAST BIRTHDAY	24 (Years)
BIRTHPLACE	Collins, MO.	BIRTHPLACE	Frazier, Idaho.
OCCUPATION	Transfer man	OCCUPATION	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 12.45 A. M. on the date above stated.

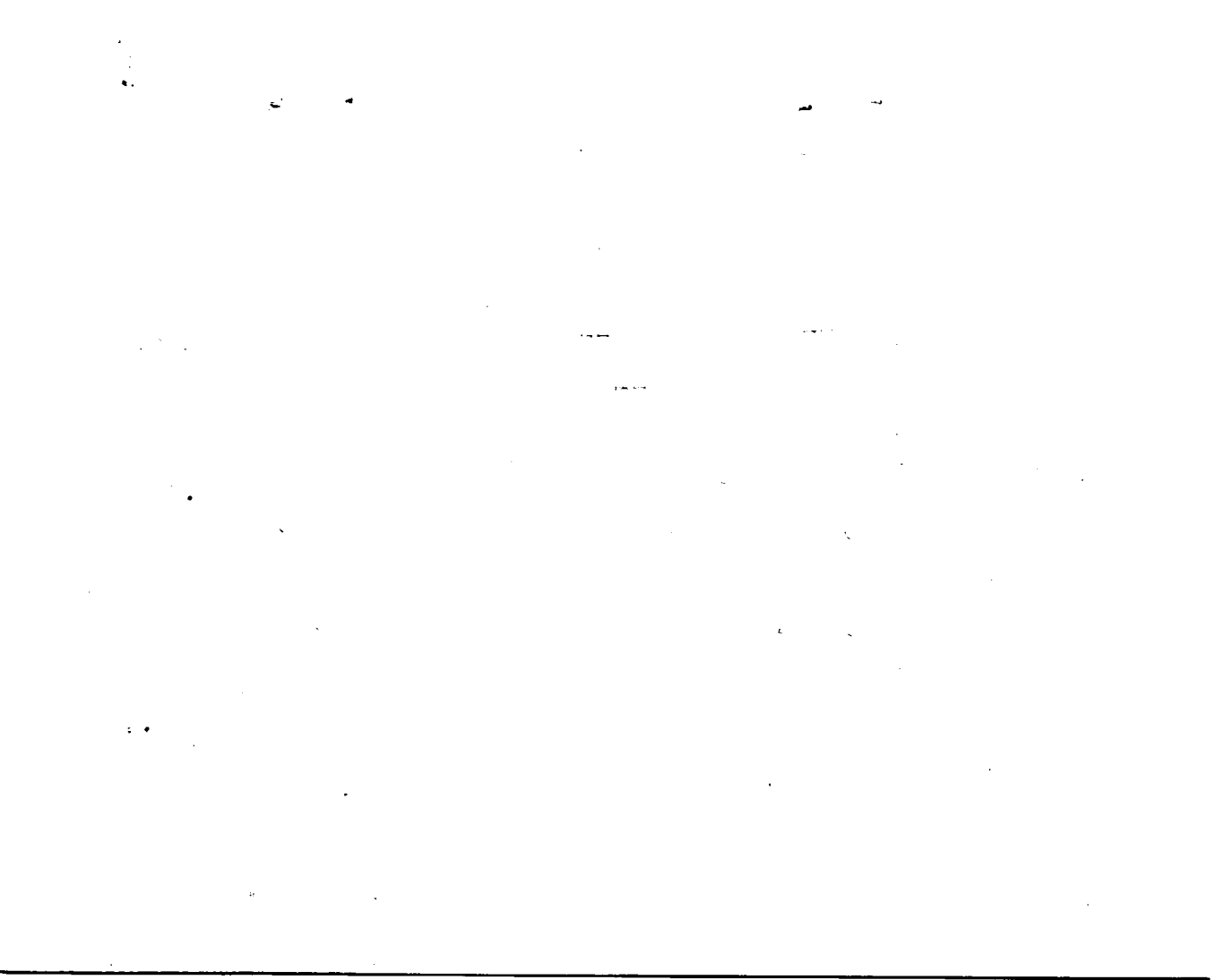
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. E. Dwyer
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Craigmont, Idaho.
Filed 8/23, 1923 R. E. Dwyer
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 50
County of Lewis
City of Winchester, Star Route
(No. St.)

File No. 42979
Registered No. 13

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Stillborn.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
Single
(Write the word.)

6. DATE OF BIRTH.

August 23 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or
min.
Yrs. Mos. 0 ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work. Infant
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Winchester, Star Route

10. NAME OF
FATHER

Thomas Elmo Garrett

11. BIRTHPLACE
OF FATHER

(State or Country) Collins, Mo.

12. MAIDEN NAME
OF MOTHER

Florence Millicent Judd

13. BIRTHPLACE
OF MOTHER

(State or Country) Frazier, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Winchester, Star Route

15.

Filed

8/23

1923

Local Registrar
Ambrose Garrett

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 23 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 23 1923 to Aug 23 1923
never im-
that I last saw h. alive on 191
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Stillborn, (Over)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. E. Durell M. D.

8/23/23 (Address) Craigmont, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death. yrs. mos. days In the State. yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

I. O. O. F. Cemetery

DATE OF BURIAL

8/23 1923

20. UNDERTAKER

ADDRESS

Winchester

As to cause of stillbirth ~~conditions~~, the following conditions were present: the cord was around the child's neck and the two veins of the cord were in a soft membrane outside the cord proper. The baby was blue. There was also present a double congenital talipes Calcareus.

R. E. Dune

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

194 726 035 731
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nevada

City of Lewiston

No. _____ St. _____

Hospital St. Joseph's

RECEIVED
SEP 8 1923
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

96 - 114681

File No. _____
Registered No. 133-A

Primary Registration District No. 1009

FULL NAME OF CHILD

St. Born Armstrong

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>8-26-1923</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? 2.0% Argysol

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 1

FATHER
FULL NAME A. N. Armstrong
RESIDENCE Lewiston, Idaho
COLOR white AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Wash
OCCUPATION Clerk

MOTHER
FULL MAIDEN NAME Lena Pearl Graves
RESIDENCE Lewiston, Idaho
COLOR white AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Missouri
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

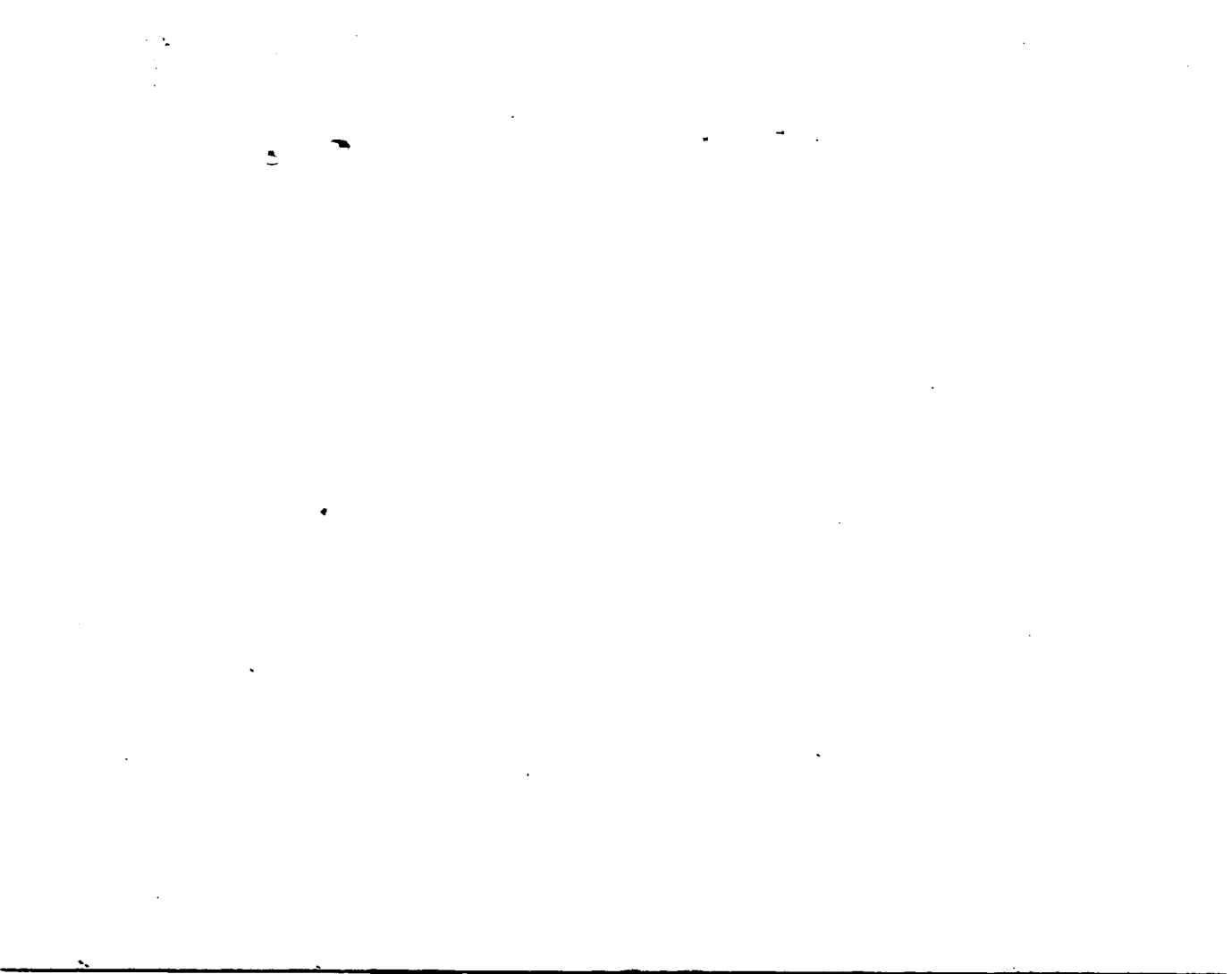
I hereby certify that I attended the birth of this child, who was Stillborn at 1.30 P. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. Carsson

Give names added from a supplemental report.
_____, 19____
_____, 19____
Registrar.

Address Lewiston, Idaho
Filed 9/1 1923
Registrar.



1. PLACE OF DEATH

RECEIVED

Registration District No.

County of Thayer

SEP 8 1923

Registration District No.

City of Lawrence

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby: Armfield

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

42983

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

Infant
(Write the word.)

6. DATE OF BIRTH

Aug - 26 - 23

7. AGE

Stillborn

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

A. M. Armfield

11. BIRTHPLACE OF FATHER

(State or Country)

Wm

12. MAIDEN NAME OF MOTHER

Paula Harris

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Armfield

(Address)

Lawrence, Mo.

15.

Filed

W. H. Hall

Local Registrar

16. DATE OF DEATH

Aug - 26 - 23

17. I HEREBY CERTIFY, That I attended deceased from

Aug 26 - 1923 to Aug 26 - 1923

that I last saw him alive on Aug 26 - 1923

and that death occurred on the date stated above, at 11:20 A. M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Carson M. D.

19. (Address) Lawrence, Mo.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lawrence, Mo.

8-27-1923

20. UNDERTAKER

ADDRESS

Wassell & Co. Lawrence, Mo.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

866129 035-347
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of neg Gene
City of Lewiston
No. _____ St. _____
Hospital St Joseph
Registration District No. 96 File No. 114682
Bureau of Vital Statistics
County Registration District No. 1009 Registered No. 135
FULL NAME OF CHILD Unnamed Norman
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes.</u>	Date of birth <u>5</u> <u>29</u> <u>1923</u> (Month) (Day) (Year)
--------------------------	---	-----------	--------------------------------	-------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 0

FATHER
FULL NAME Frank Norman
RESIDENCE Geneva
COLOR white AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Ohio
OCCUPATION Manager Farmer Union

MOTHER
FULL MAIDEN NAME Thelma Jupper
RESIDENCE Geneva
COLOR white AGE AT LAST BIRTHDAY 29
(Years)
BIRTHPLACE Ohio
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____, at _____
on the date above stated. (Born alive or stillborn) 4:30 P.M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. G. Broadbent

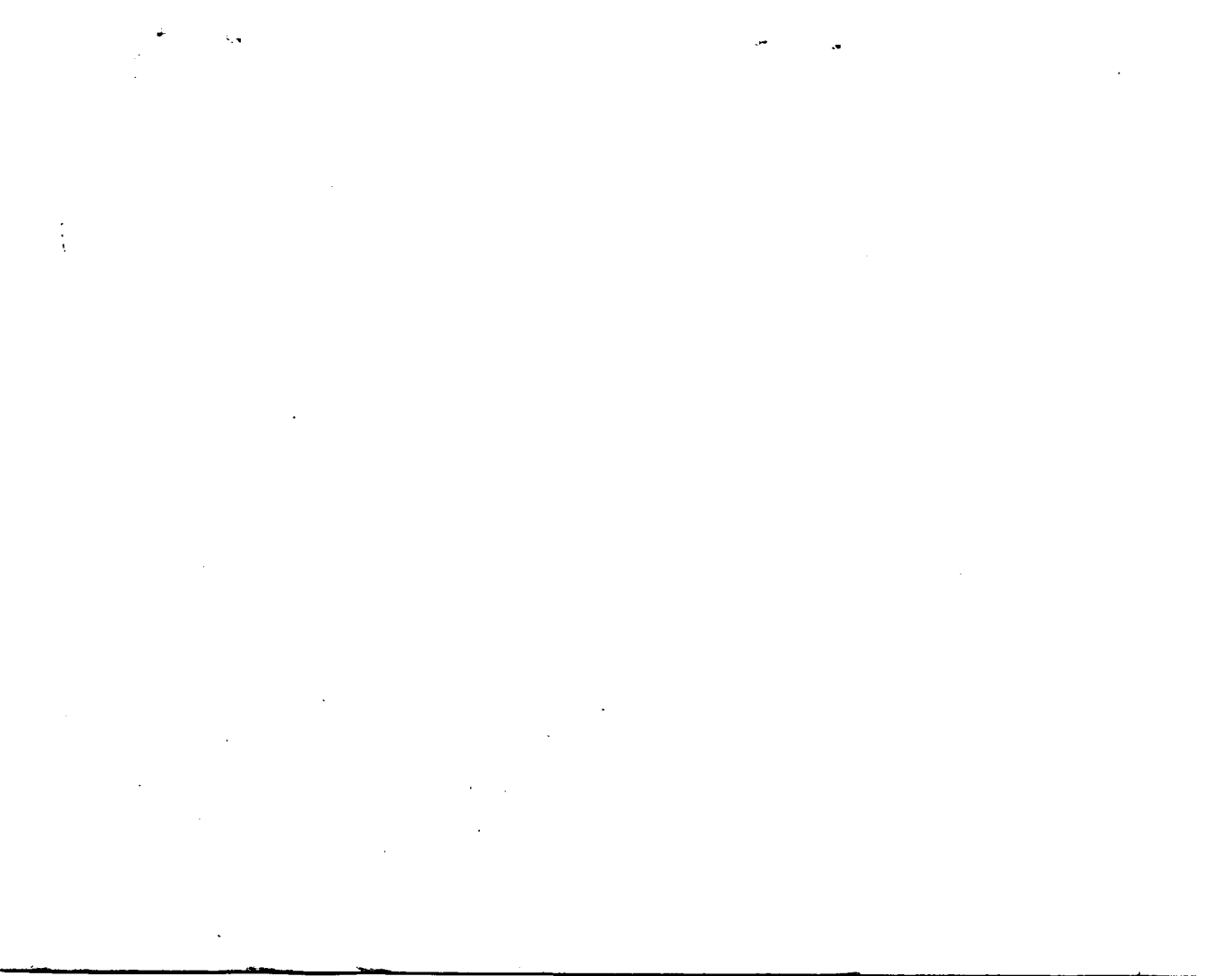
Give names added from a supplemental report.

_____, 19____

_____, 19____

Registrar.

(Physician or midwife)
Address Lewiston, Idaho
Filed 9/1 1923
Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Hayden

City of Terris

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Herman

CERTIFICATE OF DEATH

1923

SEP 8

Registration District No.

Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42982

Registered No. 175

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

813121-035-719
PLACE OF BIRTH

RECEIVED BUREAU OF VITAL STATISTICS

County of Nez Perce

SEP 10 1923

CERTIFICATE OF BIRTH

City of Fort Lapwai

BUREAU OF VITAL

STATISTICS

97

File No.

S 114703

No. _____ St. _____

Primary Registration District No. 2174Registered No. 9

Hospital _____

FULL NAME OF CHILD

Halliday

Sex of

Child

maleTwin
Triplet
or other?

{ and }

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yes

Date of

Birth

Aug. 21, 1923
(Month) (Day) (Year)FULL
NAME

FATHER

Milton Richard HallidayFULL
MAIDEN
NAME

MOTHER

Mabel Perkins

RESIDENCE

Fort Lapwai

RESIDENCE

Fort Lapwai

COLOR

WhiteAGE AT LAST
BIRTHDAY44
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY42
(Years)

BIRTHPLACE

Missouri

BIRTHPLACE

Iowa

OCCUPATION

Garage Proprietor

OCCUPATION

House wife

Number of child of this mother, including present birth

9

Number of children of this mother now living, including present birth

7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.Still born

(Born alive or stillborn)

815 a.m.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

L. F. Smith, M.D.

(Physician or midwife)

Given names added from a supplemental report

19

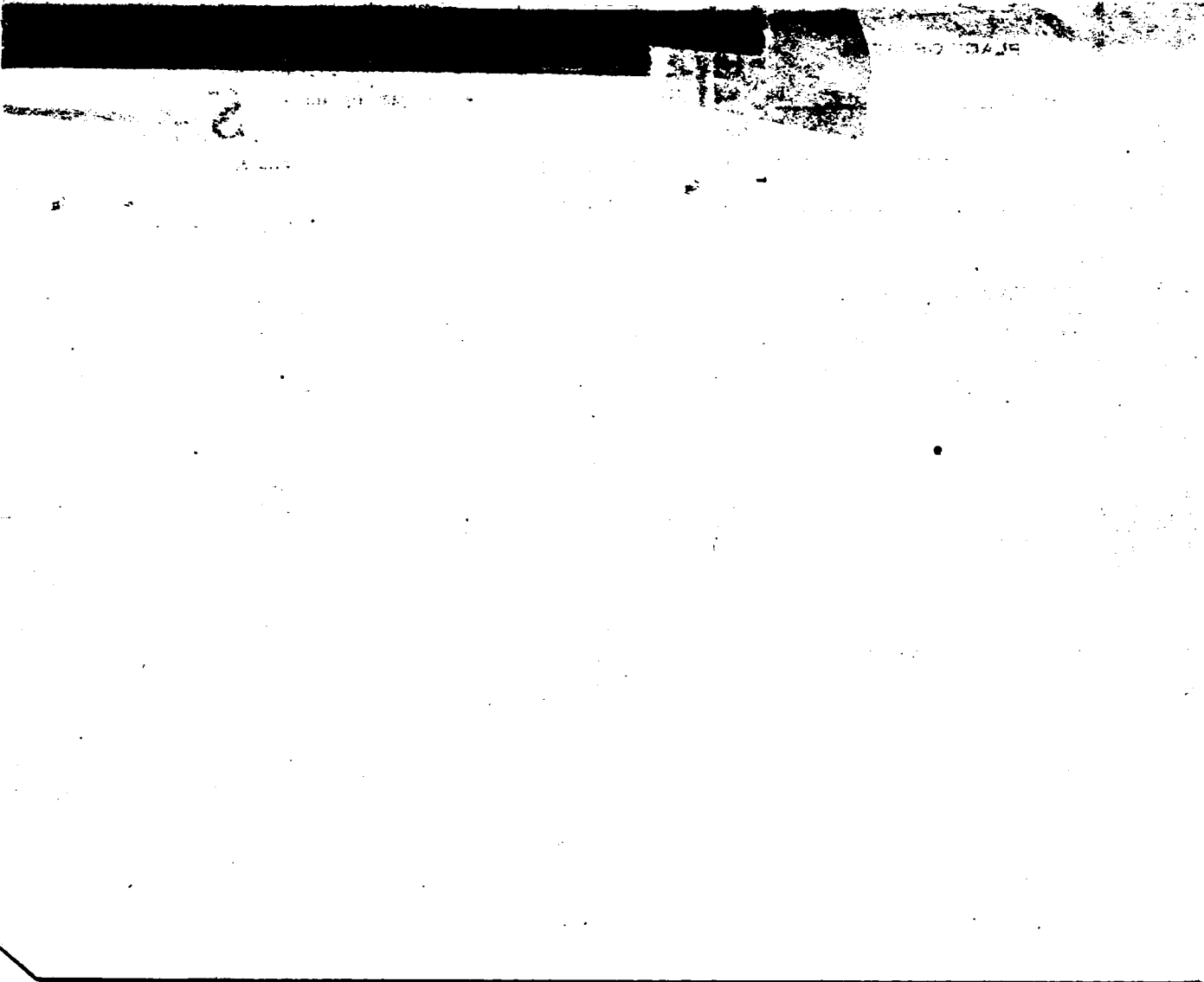
Address

Fort Lapwai

Filed

Aug. 21, 1923M. J. McJannet

Registrar



CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 76

County of Nez Perce

Registration District No. 1009

City of Lapwai

St.)

File No. 42986

Registered No. 119

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL

2. FULL NAME

Stillborn - Halliday

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

male

(Write the word.)

6. DATE OF BIRTH.

Aug 21 1923
(Month) (Day) (Year)

7. AGE

never breathed
Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Id Lapwai

10. NAME OF FATHER

Richard Halliday

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Richard Halliday

(Address)

15. Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 21 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 21 1923, to Aug 21 1923,

that I last saw him alive on Aug 21 1923,

and that death occurred on the date stated above, at 8:50 A.M.

The CAUSE OF DEATH was as follows:

Birth - Prolapse of loop of umb. cord. (pressure on)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. F. Smith M. D.

Aug 21 1923 (Address) Id Lapwai

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs....mos....days In the State...yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cemetery of Idaho

8-21-1923

20. UNDERTAKER

ADDRESS

Vassar and Co.

Cemetery

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

386-102-036-551

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Oneida

City of Malad

No. _____

Hospital _____

FULL NAME OF CHILD Shel Unsworth

RECEIVED
AUG 15 1923

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

26

114706

Registration District No.

File No.

Primary Registration District No.

2069

Registered No.

86

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>July 2</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	---	-----------	--------------------------------	------------------------	--

What bacterioidal solution was used in eyes? _____

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 8

FULL NAME George W. Thompson

FULL MAIDEN NAME Rose Evans

RESIDENCE Malad

RESIDENCE Malad

COLOR White AGE AT LAST BIRTHDAY 38
(Years)

COLOR White AGE AT LAST BIRTHDAY 38
(Years)

BIRTHPLACE Utah

BIRTHPLACE Utah

OCCUPATION Farming

OCCUPATION Housework

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. F. Allen
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Malad

_____, 19____

Filed Aug 2 1923 J. M. Turner
Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

114714

County of Oneida

City of Malad

No. _____

St. _____ District No. _____

File No. _____

Hospital _____

City Registration District No. 2069

Registered No. 94

FULL NAME OF CHILD _____

Merrill J. Bell

(Certificate of no value without full name of child.)

Sex of
Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

July 12

1923

(To be answered only in event of plural births)

(Month) (Day)

(Year)

What bacterioidal solution was used in eyes? _____

Number of child of this mother, including present birth... 2

Number of child of this mother now living, including present birth... 1

FULL
NAME

William A. Bell

FATHER

FULL
MAIDEN
NAME

Mary A. Jones

MOTHER

RESIDENCE

Malad

RESIDENCE

Malad

COLOR

White

AGE AT LAST
BIRTHDAY

2.7
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

26
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Malad

OCCUPATION

Farming

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Stillborn at _____ M.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. Fulton
J. P. Phipps
Physician or midwife

Give names added from a supplemental report.

Address _____

Filed 8/2 1923

Registrar.

J. M. Kerns
Deputy Registrar.

2

1945

407

Boise, Idaho 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY <u>Cherry Creek</u>	FILE NO. <u>14714</u>
	(ST. <u> </u>	DATE OF BIRTH <u>July 12, 1923</u>
	(COUNTY <u>Osnida</u>	SEX OF CHILD <u>Male</u>
	FATHER <u>Wm. A. Bell</u>	MOTHER <u>Mary A. Jones</u> (Maidee Name)

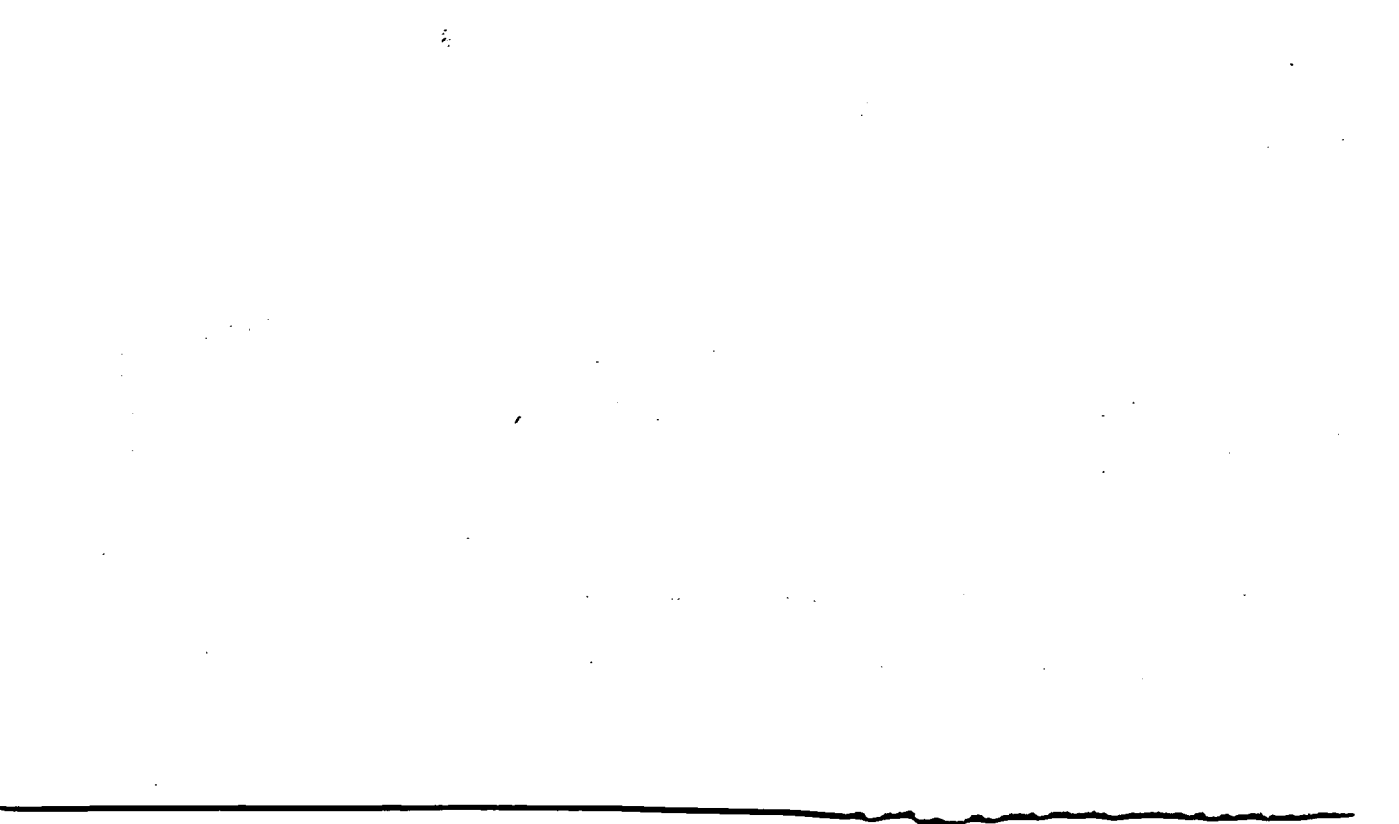
I HEREBY CERTIFY that the child herein described has been named.

Merrill J. Bell

Mary A. Bell

Signature of Father or Mother.

RECEIVED
JUL 15 1923



CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BradaCity of Cherry Creek

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26Primary Registration District No. 2069

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 43002Registered No. 78

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child (ord.)

6. DATE OF BIRTH

July 12 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cherry Creek Idaho

10. NAME OF FATHER

Wm A. Bell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary A. Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm A. Bell

(Address)

Cherry Creek

15.

Filed July 12 1923 M. Korno
Def Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 12 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

July 12 1923

(Address)

Stillborn
Maial

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

369-219 039-293

PLACE OF BIRTH

County of PowerCity of Amer. Falls

No. _____ St. _____

Hospital Bethany

FULL NAME OF CHILD _____

RECEIVED
STATE OF IDAHO
BUREAU OF VITAL STATISTICS
AUG 24 1923
BUREAU OF VITAL
STATISTICS
Registration District No. 25

Form V. S. No. 11-C-25m-7-21-19

S114743

File No. 11Primary Registration District No. 2072Registered No. 541

Sex of Child Female Twin Triplet or other? — and — Number in order of birth — Legiti mate? Yes Date of Birth June 19 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER
FULL NAME Lavern Cornwall
RESIDENCE Pocatello Ida
COLOR White AGE AT LAST BIRTHDAY 22
(Years)
BIRTHPLACE Ida

OCCUPATION Electrician

MOTHER
FULL MAIDEN NAME Geneva Siler
RESIDENCE Same
COLOR White AGE AT LAST BIRTHDAY 22
(Years)
BIRTHPLACE Idaho

OCCUPATION HousewifeNumber of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at 10 A M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

C. F. Schieb

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Amer. FallsFiled Aug 1 1923

Registrar

Genevieve Noth
By H. F. J. J. J.
Registrar

1991

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

SEP 12 1923

Boise, Idaho _____ 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY _____	FILE NO. _____
	(ST. _____	DATE OF BIRTH _____
	(COUNTY _____	SEX OF CHILD _____
	(FATHER _____	MOTHER _____

(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Signature of Father or Mother.



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

68-129 001-395

RECEIVED

PLACE OF BIRTH

1923

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

1-C-25m-7-21-19

County of Ada BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

414855

City of Barber

Registration District No. 8

File No. 118455

No. _____ St.

Primary Registration District No. 2008

Registered No. 69

Hospital _____

FULL NAME OF CHILD

Stillborn

Sex of Child <u>M</u>	Age in <u>Weeks</u> <u>41</u> and <u>Months</u> <u>41</u> in order of birth (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>8/29/23</u> (Month) (Day) (Year)
-----------------------	---	------------------------	--

FATHER
Thomas L. Johnson
RESIDENCE 34-2nd St. - Barber
COLOR W. AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Idaho
OCCUPATION Lumberman

MOTHER
Rose Creech
RESIDENCE 34-2nd St. Barber
COLOR W. AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Kentucky
OCCUPATION Housewife

Number of child of this mother, including present birth _____ Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2:05 P.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ernest E. Lambaugh
M.D.
(Physician or midwife)

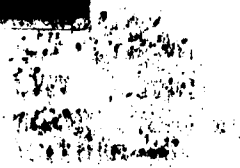
Given names added from a supplemental report.

19

Address Boise, Idaho
Filed Sept 30 1923 R.N. Pratt
Registrar

Registrar

Registrar



SP

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
NOV 13 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2008

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 43370

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

August 29, 23
(Month) (Day) (Year)

7. AGE

still-born

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Barber, Idaho

10. NAME OF FATHER

E. L. Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Ann Cressick

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ernest E. Lathrop
Boise, Idaho

15. File

Aug 30 1923

R. N. Oak

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 29 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

still-born
Probable cord.

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed) Ernest E. Lathrop M. D.

9/11/23 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried at Barber, Aug 30 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

85-221002-344
PLACE OF BIRTH

County of Adams

City of Goodrich

No. _____ St. _____

Hospital _____

Full Name of Child _____

RECEIVED
OCT 9 1923
BUREAU OF VITAL STATISTICS
Register District No. _____

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-25m-4-14

114879

File No. _____

Registered No. _____

Primary Registration District No. _____

Floyd Allen Wheeler

SEX OF CHILD <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number in order of birth { and }	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>July 21</u> (Month) (Day) (Year)
FULL NAME <u>Clifford A. Wheeler</u>	FATHER		FULL MAIDEN NAME <u>Mella Cude</u>	MOTHER
RESIDENCE <u>Goodrich</u>			RESIDENCE <u>Goodrich</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)		COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>17</u> (Years)
BIRTHPLACE <u>N.Y.</u>			BIRTHPLACE <u>Tex</u>	
OCCUPATION <u>Section hand</u>			OCCUPATION <u>House wife</u>	

Number of child of this mother, including present birth... 1 Number of children of this mother now living, including present birth... 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was a MONTROVILE (Born alive or stillborn), at 107 on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. M. Brown

(Physician or midwife)

Given names added from a supplemental report.

Address Goodrich

Filed July 31 1923 M. M. Brown
Registrar

100 17 OF 1711

2013

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho OCT 22 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Boise
(ST. _____
(COUNTY Adams
FATHER Clifford

FILE NO. 114879
DATE OF BIRTH July 21 - 1923
SEX OF CHILD Male
MOTHER Maria Wether
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Floyd A. Wether

Mrs. Clifford A. Wether

Signature of Father or Mother

RECEIVED
OCT 31 1923
BUREAU OF VITAL STATISTICS

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 253107 23-432
County of Bennett
City of Pocatello
No. 1 St. Registration District No. 28 State File No. 10430
Hospital Pocatello Primary Registration District No. 2161 Local Registrar's No. 4084
BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
114898
S
CERTIFICATE OF BIRTH
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and { Number in order of birth }	Legitimate? <u>yes</u>	Date of birth <u>9-7-1923</u> (Month) (Day) (Year)
--------------------------	---	----------------------------------	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 0

FATHER FULL NAME <u>A. Victor Beckstead</u> RESIDENCE <u>Pocatello Idaho</u> COLOR <u>wht</u> AGE AT LAST BIRTHDAY <u>28</u> (Years) BIRTHPLACE <u>Utah</u> OCCUPATION <u>Express - R.R.</u>	MOTHER FULL MAIDEN NAME <u>Shucilla M. Ray</u> RESIDENCE <u>same</u> COLOR <u>wht</u> AGE AT LAST BIRTHDAY <u>28</u> (Years) BIRTHPLACE <u>Idaho</u> OCCUPATION <u>Housewife</u>
---	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

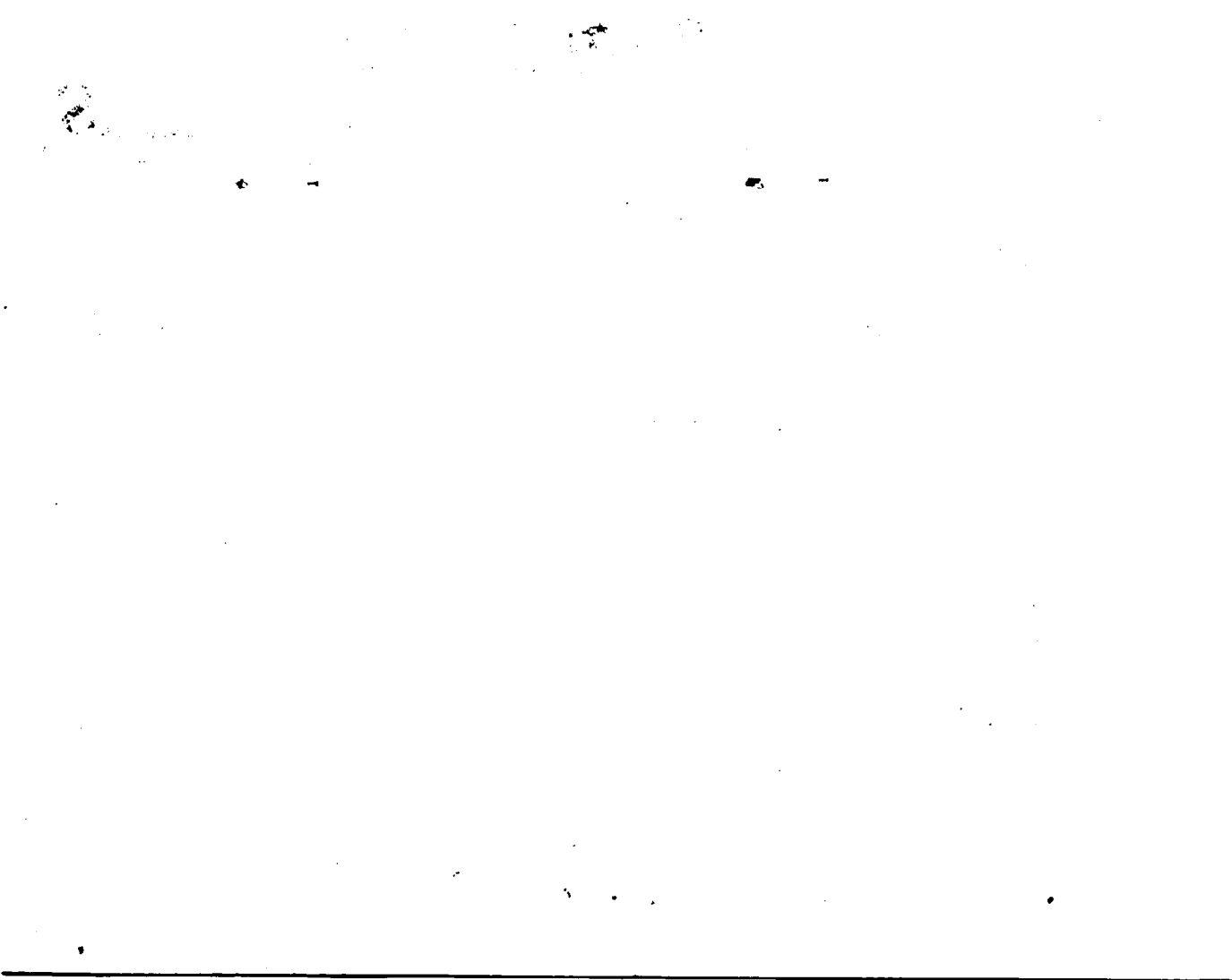
(Signature) J. C. Ray

(Physician or midwife)

Give names added from a supplemental report.

Address Pocatello Idaho
Filed 11/1 1923 Registrar J. C. Ray

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED

OCT 13 1923

Registration District No. 28

BUREAU OF VITAL STATISTICS

Registration District No. 2141

(No. St.)

1. PLACE OF DEATH

County of *Bannock*
City of *Pocatello*
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Beckstead*State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 43091

Registered No. 4167

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Still Born

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF FATHER

W. Victor Beckstead

11. BIRTHPLACE OF FATHER

(State or Country)

Provo Utah

12. MAIDEN NAME OF MOTHER

Jemima McKay

13. BIRTHPLACE OF MOTHER

(State or Country)

Malad Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Victor Beckstead

(Address)

Pocatello Ida.

15.

Filed *9-7-23* 1923*R. E. Johnson*

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Sept**7**23*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-7

191

to

9-7

1923

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature birth from nephritis

(Duration) Yrs. mos. ds.

Contributory

(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

D. C. Ray

M. D.

9-7-23 (Address) *Pocatello*

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad Ida.

DATE OF BURIAL

9-7-23

20. UNDERTAKER

R. E. Johnson

ADDRESS

Burley Ida.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Sienographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers, who receive a definite salary*) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles: Whooping cough: Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 713-215-83693
County of Sanrock
City of Pocatello
No. 1 St. 1 Registered District No. 28 State File No. 114911
Hospital Pocatello Primary Registration District No. 3161 Local Registrar's No. 4097

RECEIVED
OCT 13 1923
BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
114911

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>J</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Sept 15</u> , 192 <u>3</u> (Month) (Day) (Year)
-----------------------	-----------------------------------	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? 1

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME <u>Chas Vernon Palmer</u>	FULL MAIDEN NAME <u>Hannah M. Williams</u>		
RESIDENCE <u>Pocatello Idaho</u>	RESIDENCE <u>same</u>		
COLOR <u>wht</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>wht</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Labourer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 39 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) D C Ray

(Physician or midwife)

Address Pocatello Idaho

Filed 10/1 1923

Registrar.

Registrar.

PROCEED WITH CAUTION. A CERTAINLY NOT CRIMINAL. THE FOLLOWING INFORMATION IS FOR THE USE OF THE BUREAU OF VITAL STATISTICS. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE BUREAU OF VITAL STATISTICS.

PLACE OF BIRTH

BUREAU OF VITAL STATISTICS

DEPARTMENT OF HEALTH

PRIMA RY REGISTRATION DISTRICT NO.

CERTIFICATE OF NO VALUE WITHOUT NAME OF CHILD

What birth certificate number was used in event

Number of child in this mother, including present birth

Number of child of this mother now living, including present birth

FATHER

MOTHER

AGE AT LAST BIRTHDAY

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

(Signature)

Physician or midwife

Address

File

When there was no attending physician or midwife, then the father, mother, or another make this report. A physician or midwife is one that neither observes nor shows other evidence of the birth.

Have mother signed from a governmental agent.

1921

Register

1921

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant PalmerRECEIVED
CERTIFICATE OF DEATHRegistration District No. 28BUREAU OF VITAL STATISTICS
Registration District No. 2141
(No. 855 St. Hamm)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 43193Local Registrar's No. 4173

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Sept 15 1923
(Month) (Day) (Year)

7. AGE

Still BornIF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Pocatello Idaho

10. NAME OF FATHER

Charles V Palmer

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mrs Tanny Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Charles V Palmer
Pocatello Idaho

15.

Filed Sept - 14 1923Sam B. Bault
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 16 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1923 to 9-15-23, that I last saw him live on 9-15- 1923, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Died in uterus
probably strangulated
cord

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9-16-1923 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Idaho Sept 16 1923

20. UNDERTAKER

ADDRESS

H. A. Mc Han Pocatello Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

114993

BUREAU OF VITAL STATISTICS

County of IdahoCity of Pocatello

SEP 14 1923

CERTIFICATE OF BIRTH

No. 225St. 14

BUREAU OF VITAL STATISTICS

28

State File No.

Hospital 599-110003-613Primary Registration District No. 2141Local Registrar's No. 6000FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child

MaleTwin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birthLegiti-
mate?YesDate of
birthAug 10, 1923

(Month) (Day) (Year)

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 5Number of child of this mother now living, including present birth 4FULL
NAME

FATHER

Emile Erickson

RESIDENCE

Pocatello Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY43
(Years)FULL
MAIDEN
NAME

MOTHER

Eugene Wallin

RESIDENCE

Pocatello Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY33
(Years)

BIRTHPLACE

Sweden

BIRTHPLACE

Sweden

OCCUPATION

Contractor

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. H. Hadden

(Physician or midwife)

Give names added from a supplemental report.

Address Pocatello IdahoFiled 9-1 1923

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Give names of persons who had been seen with

1. When there was no attending physician or midwife and the father, nurse, janitor, etc., should make this return. A physician's bill is one that neither proves nor shows other evidence of illegitimacy.

DATA ABOVE NOT TO BE USED

I hereby certify that I attended the birth of this child, who was

211110

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

OCUPATION

BIRTHPLACE

000000

ALL AT LAST
BIRTHDAY

[illegible]

ସଫଳତାପ୍ରାପ୍ତି

EMAP

ЯВЛЯЕТСЯ

Number of child of this mother, including present birth

number of child of this mother now living, including present birth

OCCUPATION

1895年

COLO

ADHITDA

RESIDENCE

1301AM

5134TQM

number of child of this mother now living, including present birth

What bacterial solution was used in operation?

19

1992

7-20-2000

10

1000

(Continued) No value without full name of child

FILE NAME OF ORIGIN

Partnership Registration No.

104501

Российская Федерация

OK 411 43418

CELEBRATION OF BIRTH

3311

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County *Pocatello* Registration District No. *25*City of *Pocatello* Registration District No. *11*

If death occurs away from usual residence, give facts called for under special information.

-2. FULL NAME

*Infant Erickson*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *43073*
Registered No. *4138*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*9/11**1923*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 10 19*23*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Aug 10, 1923*, to *Aug 10, 1923*, that I last saw him alive on *Stillborn* 19*23*, and that death occurred on the date stated above, at *7:00* M. The CAUSE OF DEATH* was as follows:*Stillborn, Anencephalus*(Duration) Yrs. *7* mos. *7* ds.

Contributory (Secondary)

(Duration) Yrs. *7* mos. *7* ds.

(Signed)

W. N. Bradden M. D.*8/10 1923*(Address) *Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. *7* mos. *7* days. In the State Yrs. *7* mos. *7* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain View**Aug 11, 1923*

20. UNDERTAKER

ADDRESS

*Schumacher Hall**Pocatello Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

219-021
005-113

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form 115001-9-3-17

County of *Bennett*

SEP 15 1923

CERTIFICATE OF BIRTH

City of *Near Plummer*

BUREAU OF VITAL
STATISTICS

46

S-115001

File No.

No. St.

Primary Registration District No. *2123*

Registered No. *10*

Hospital

FULL NAME OF CHILD *Winnaud Burchett*

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <i>yes</i>	Date of Birth <i>Aug 21 1923</i> (Month) (Day) (Year)
--------------	---	--------------------------------------	-----------------------------	--

FULL NAME	FATHER <i>Edward Burchett</i>
RESIDENCE	<i>Bennett Co</i>
COLOR	<i>W</i>
BIRTHPLACE	<i>Idaho</i>
OCCUPATION	<i>Farmer</i>

FULL MAIDEN NAME	MOTHER <i>Clara Eleanor Jacobson</i>
RESIDENCE	<i>Bennett Co</i>
COLOR	<i>W</i>
BIRTHPLACE	<i>Minnesota</i>
OCCUPATION	<i>House wife</i>

Number of child of this mother, including present birth. *3* ... Number of children of this mother now living, including present birth. *2*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* at *5 P* M on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *J. A. Nelson*

Given names added from a supplemental report.

Address *Boise, Idaho*

File *Sept 28 1923*

Registrar

Registrar

1945-1946



1945-1946

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Beauvois Co.*
City of *Plummer*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *46*
Primary Registration District No. *2123*
(No. *46* St.)

Unmailed Buchett

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *43123*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WID-OWED OR DIVORCED _____

(Write the word.)

6. DATE OF BIRTH

Aug 21 1923
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Beauvois Co

10. NAME OF FATHER

Ed Buchett

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Clara Eleanor Buchett

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos E. Buchett Jr.

(Address)

Plummer Ida

15.

Filed

Sept 28 1923

Thos E. Buchett Jr.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still Born
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

that I last saw him _____ alive on _____ 19____, and that death occurred on the date stated above, at _____ M.

THE CAUSE OF DEATH* was as follows:

Pneumonia & claustrum in mother before birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. A. Nelson M. D.

9/27 1923

(Address)

Idaho, Wm

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Plummer Ida

DATE OF BURIAL

Sept 29 1923

20. UNDERTAKER

C. L. Schulz

ADDRESS

Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of Bingham

City of Blackfoot

No. 501 E. Pacific St.

Hospital 792-246006-473

FULL NAME OF CHILD

RECEIVED

OCT 6 1923

BUREAU OF VITAL

STATISTICS

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

15095

Registration District No. 121

State File No. 121

Primary Registration District No. 1017

Local Registrar's No. 318

(Certificate of no value without full name of child)

Sex of Child

Female

Twins
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Sept 16

(Month)

(Day)

1923
(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

5

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER

Willard E. Hansen

RESIDENCE

Blackfoot

COLOR

White

AGE AT LAST
BIRTHDAY

57

(Years)

BIRTHPLACE

Utah

OCCUPATION

Farming

FULL
MAIDEN
NAME

MOTHER

Lottie Malm

RESIDENCE

Blackfoot

COLOR

White

AGE AT LAST
BIRTHDAY

41

(Years)

BIRTHPLACE

Sweden

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8:45 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

W. Beck

(Physician or Midwife)

Address

Blackfoot, Id.

Filed

Oct. 4 1923

Registrar.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
43138
File No.
Registered No. 101

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121

BUREAU OF VITAL STATISTICS

Registration District No. 1007

St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

No name Gibby

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept 16 1923
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
FATHER

Willard E. Gibby

11. BIRTHPLACE
OF FATHER

(State or Country)

Utah

12. MAIDEN NAME
OF MOTHER

Lottie Malm

13. BIRTHPLACE
OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willard E. Gibby

(Address)

Blackfoot, Idaho

15.

Filed

Sept 17 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 16 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born due to placenta previa at 5 1/2 mos.
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. W. Beck M. D.

9/17 1923 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Grove City, Ind. 19

20. UNDERTAKER ADDRESS

J. E. Gibby

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

DATE OF BIRTH		RECEIVED		STATE OF IDAHO	
OCT 3 1923		DEPARTMENT OF PUBLIC WELFARE		115105	
BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		115105	
City of <u>Carey</u>		CERTIFICATE OF BIRTH		115105	
No. <u>453114007864</u>		Registration District No. <u>57</u>		State File No. <u>55</u>	
Hospital		Primary Registration District No. <u>2025</u>		Local Registrar's No. <u>55</u>	
FULL NAME OF CHILD		<u>Steelborn</u>			
		(Certificate of no value without full name of child)			
Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Date of birth
<u>Male</u>	<u>Yes</u>		<u>1st</u>	<u>Yes</u>	<u>8 14 1923</u>
	(To be answered only in event of plural births)			(Month)	(Day) (Year)
What bactericidal solution was used in eyes? <u>None</u>					
Number of child of this mother, including present birth <u>6</u>			Number of child of this mother now living, including present birth <u>4</u>		
FATHER			MOTHER		
FULL NAME <u>G. Wallace Mechem</u>			FULL MAIDEN NAME <u>Emma F. Young</u>		
RESIDENCE <u>Carey</u>			RESIDENCE <u>Carey</u>		
COLOR <u>White</u>			COLOR <u>White</u>		
AGE AT LAST BIRTHDAY <u>37</u> (Years)			AGE AT LAST BIRTHDAY <u>37</u> (Years)		
BIRTHPLACE <u>Utah</u>			BIRTHPLACE <u>Utah</u>		
OCCUPATION <u>Farmer</u>			OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:10-5:15 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Houston E. Snyder
Physician
(Physician or midwife)

Address

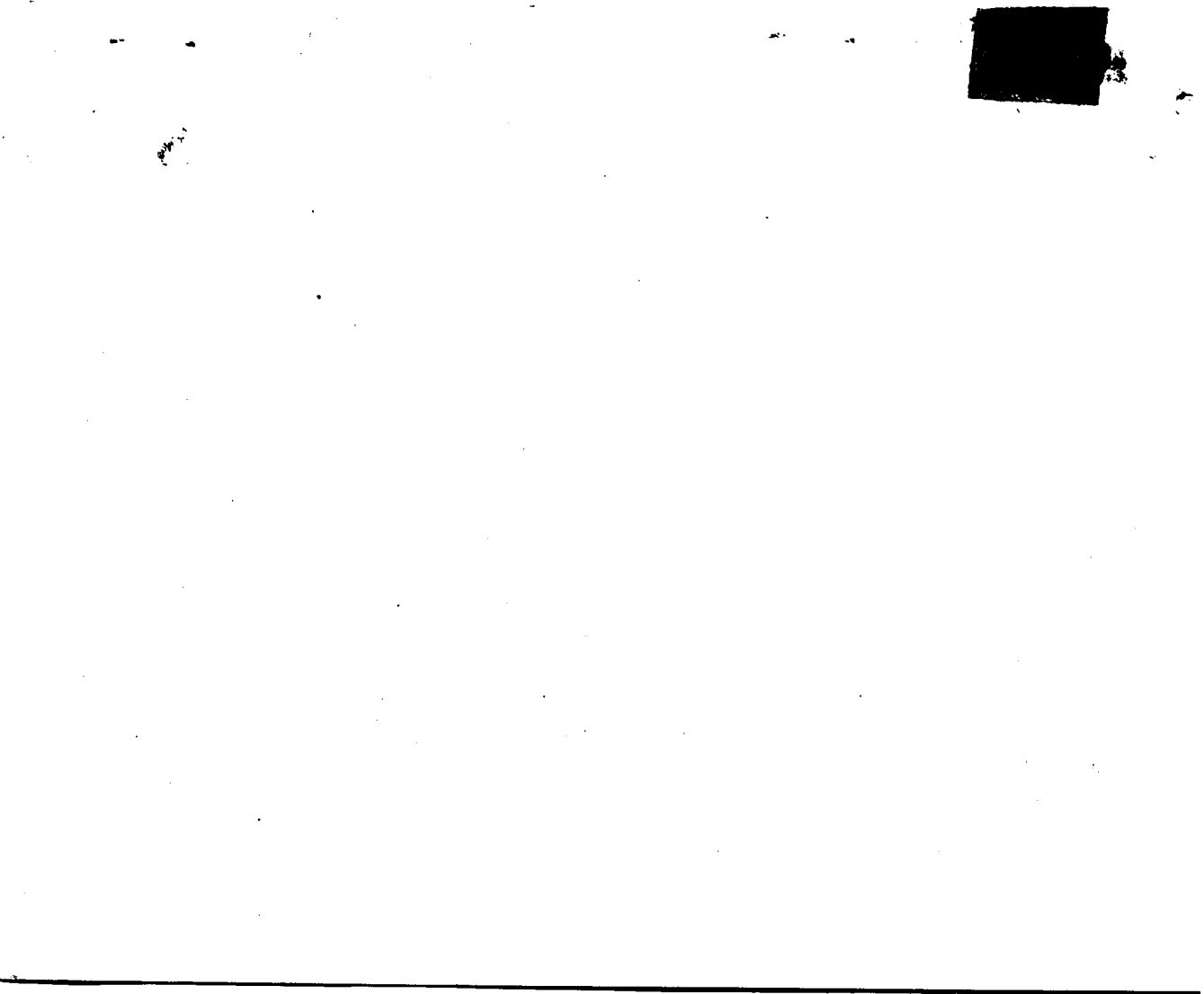
Carey Idaho

Filed

10-1 1923

Registrar.

Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

OCT 8 1923 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 43148
Registered No. 38

1. PLACE OF DEATH

County of Blaine District No. 57
City of Carey (No. _____) St. _____
Primary Registration District No. 2075

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Mechem

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED# Male White Single
(Write the word.)

6. DATE OF BIRTH

8 14 1923
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Infant
Baby.

9. BIRTHPLACE

(State or Country)

Blaine Co Idaho

10. NAME OF FATHER

G. Wallace Mechem

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Emma F Young

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Houston E Snyder
Carey Idaho

15.

Filed

15 - 11923R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 14 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
8-14 1923 to 8-14 1923that I last saw h. _____ alive on Still born
and that death occurred on the date stated above, at X M.

The CAUSE OF DEATH* was as follows:

Placenta Previa

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Houston E Snyder M. D.

19

(Address)

Carey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carey, Ida8/15/1923

20. UNDERTAKER

ADDRESS

✓

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH
453114007.864
County of Blaine
City of Carey
No. 57
Hospital Stielborn
Primary Registration District No. 2075
FULL NAME OF CHILD Stielborn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
115106
RECEIVED
OCT 3 1923
BUREAU OF VITAL STATISTICS
Certificate of Birth
File No. 115106
Registered No. 56

Sex of Child Male Twin Yes Triplet or other? and Number in order of birth 258 Legitimate? Yes Date of birth 8 14 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes? none
Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

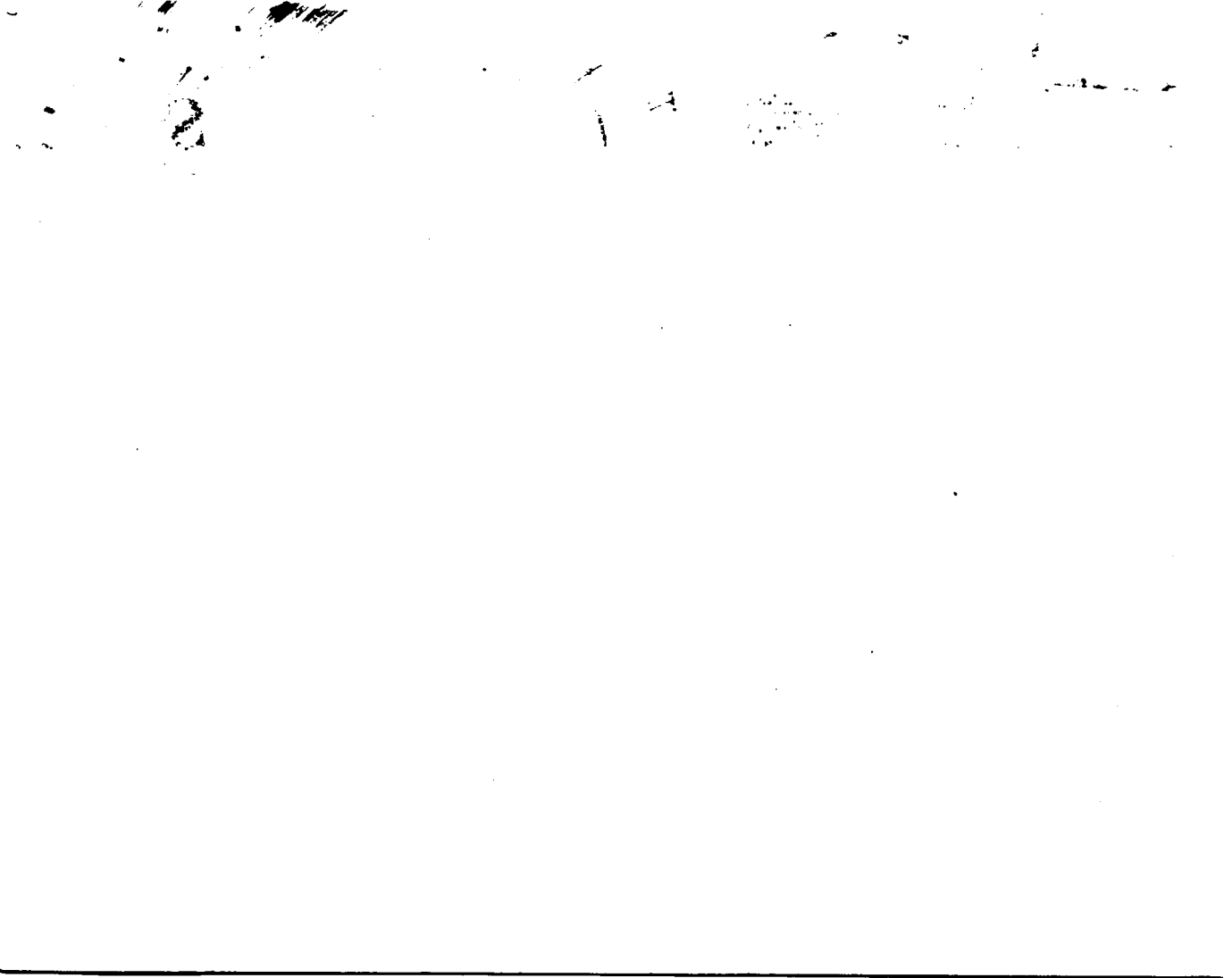
FATHER		MOTHER	
FULL NAME	<u>G. Wallace Mechem</u>	FULL MAIDEN NAME	<u>Emma F. Young</u>
RESIDENCE	<u>Carey, Ida</u>	RESIDENCE	<u>Carey, Ida</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>37</u> (Years)	AGE AT LAST BIRTHDAY	<u>27</u> (Years)
BIRTHPLACE	<u>Utah</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
I hereby certify that I attended the birth of this child, who was Stielborn at 5:15 P.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Houston E. Snyder

Give names added from a supplemental report.
Address Carey - Ida
Filed 10-1 1923 Robert H. Wright
Registrar. Registrar.



1. PLACE OF DEATH

County of Blaine
City of Carey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shelborn

RECEIVED CERTIFICATE OF DEATH

OCT 3 1923

BUREAU OF VITAL STATISTICS

Registration District No. 57
Health District No. 2075
(Name) _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 43149
Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Infant-
(Write the word.)

6. DATE OF BIRTH

8 14 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Twin Baby

9. BIRTHPLACE

(State or Country) Blaine Co. Ida

10. NAME OF FATHER

G. Wallace Mecham

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MARRIED NAME OF MOTHER

Emma F. Young

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Houston E. Snyder
(Address) Carey, Ida

15. Filled 10-1 1923 P. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 14 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-14 1923 to 8-14 1923

that I last saw him alive on Shelborn 19and that death occurred on the date stated above, at X M.

The CAUSE OF DEATH* was as follows:

Placenta Previa

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Houston E. Snyder M. D.8/15 1923 (Address) Carey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Carey - Ida 8/15 1923

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

853-229 009/193

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115134

County of Bonner

OCT 8 1923

CERTIFICATE OF BIRTH

City of Sandpoint

BUREAU OF VITAL

STATISTICS

No.

St.

Registration District No.

78

File No.

Hospital City

Primary Registration District No.

2155

Registered No.

FULL NAME OF CHILD

still born

(Certificate of no value without full name of child.)

Sex of

Child female

Twin
Triplet
or other?

{ and }

Number
in order
of birthLegiti-
mate?

yes

Date of

birth 9/29/23

192

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? ~~iodine~~

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

Vera Earl Hollar

FULL
MAIDEN
NAME

MOTHER

Bertha Elizabeth Orcutt

RESIDENCE

Sandpoint

RESIDENCE

Sandpoint

COLOR

White

AGE AT LAST

BIRTHDAY 24

(Years)

COLOR

White

AGE AT LAST

BIRTHDAY 20

(Years)

BIRTHPLACE

Mo.

BIRTHPLACE

Wyo.

OCCUPATION

laborer

OCCUPATION

Haw.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 7 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

N. R. Hultberg

M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Sandpoint

Filed

Oct 4 1923

Viola Allen

Registrar.

Registrar.

2

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Banner
City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Still born

CERTIFICATE OF DEATH

Registration District No. 76Registration District No. 2155

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 43427

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single (the word.)

6. DATE OF BIRTH

9/29/23

(Month)

(Day)

1 (Year)

7. AGE

still born

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed.

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Vera Earl Hollar

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Bertha Elizabeth Orcutt

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Bertha E. Hollar(Address) Sandpoint Idaho

15.

Filed Sept 30 1923Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9/29/23

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19, to 19,

that I last saw him alive on 19,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth, of 5 months gestation, due to a fall of the mother.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

19 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

819-201-009-363

RECEIVED

OCT 8 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115139

County of Banner

City of Cabinet

CERTIFICATE OF BIRTH

No. _____

St. _____

BUREAU OF VITAL
STATISTICS

Registration District No. _____

File No. _____

Hospital _____

Primary Registration District No. 2155

Registered No. _____

FULL NAME OF CHILD _____

still born

(Certificate of no value without full name of child.)

Sex of
Child _____

Twin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth

Legiti-
mate?

Date of
birth 5/1/23

192____
(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... 2

Number of child of this mother now living, including present birth... 0

FULL
NAME

FATHER

David Daniel Harris

FULL
MAIDEN
NAME

MOTHER

Mary Jane Cochran

RESIDENCE

Cabinet

RESIDENCE

Cabinet

COLOR

white

AGE AT LAST
BIRTHDAY 27

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY 26

(Years)

BIRTHPLACE

Minn

BIRTHPLACE

Wash

OCCUPATION

farmer

OCCUPATION

h.w.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at _____ M.
on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Viola Allen

M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address _____

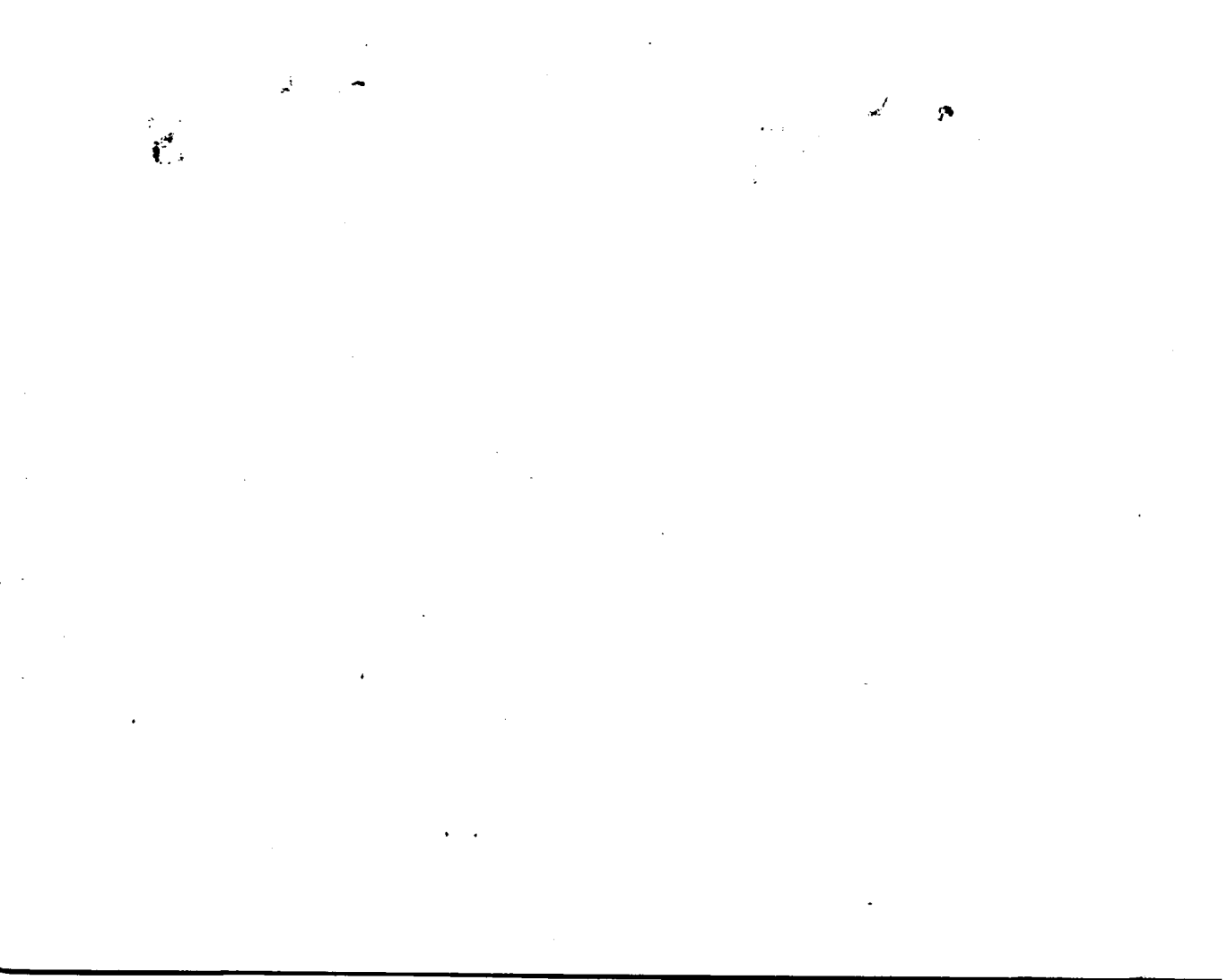
Sandpoint

Filed

Oct 4 1923

Viola Allen
Deputy Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 10 1923
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Banner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 76

Primary Registration District No. 2155

(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43426

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write in word.)

6. DATE OF BIRTH 9/1/23
(Month) (Day) (Year)

7. AGE still born IF LESS than 1 day how many _____ hrs. or _____ min.?
Yrs. _____ Mos. _____ ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (for employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER David Daniel Harris

11. BIRTHPLACE OF FATHER Minn.
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Jane Cochran

13. BIRTHPLACE OF MOTHER Wash
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David D. Harris
(Address) Cabinet

15. Filed Sept 1 1923
Viola Allers Local Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9/1/23

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw h_____ alive on _____ 19____, and that death occurred on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows:

Still born, probably due to asphyxiation from cord around neck in breech presentation, birth having occurred before I arrived.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. R. Wallington M. D.

9/4/23 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cabinet DATE OF BURIAL Sept 1 1923

20. UNDERTAKER David Harris ADDRESS Cabinet, Ida.
Father

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill;* (a) *Salesman, (b) Grocery;* (a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

556-120 014-799
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115245

County of Canyon
City of Nampa

RECEIVED
OCT 6 1923

CERTIFICATE OF BIRTH

S

No. 7 File No. 7
Hospital Mercy Primary Registration District No. 2006 Registered No. 7

FULL NAME OF CHILD

Therese Combe
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input checked="" type="checkbox"/> and <input checked="" type="checkbox"/> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Sept 30</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	--	------------------------	---

What bactericidal solution was used in eyes? 1% Silver Nitrate Solution

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Lewis E. Newcombe
RESIDENCE Melba, Ida.
COLOR white AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE California
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Helean Trick
RESIDENCE Melba Ida
COLOR white AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Wisconsin
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

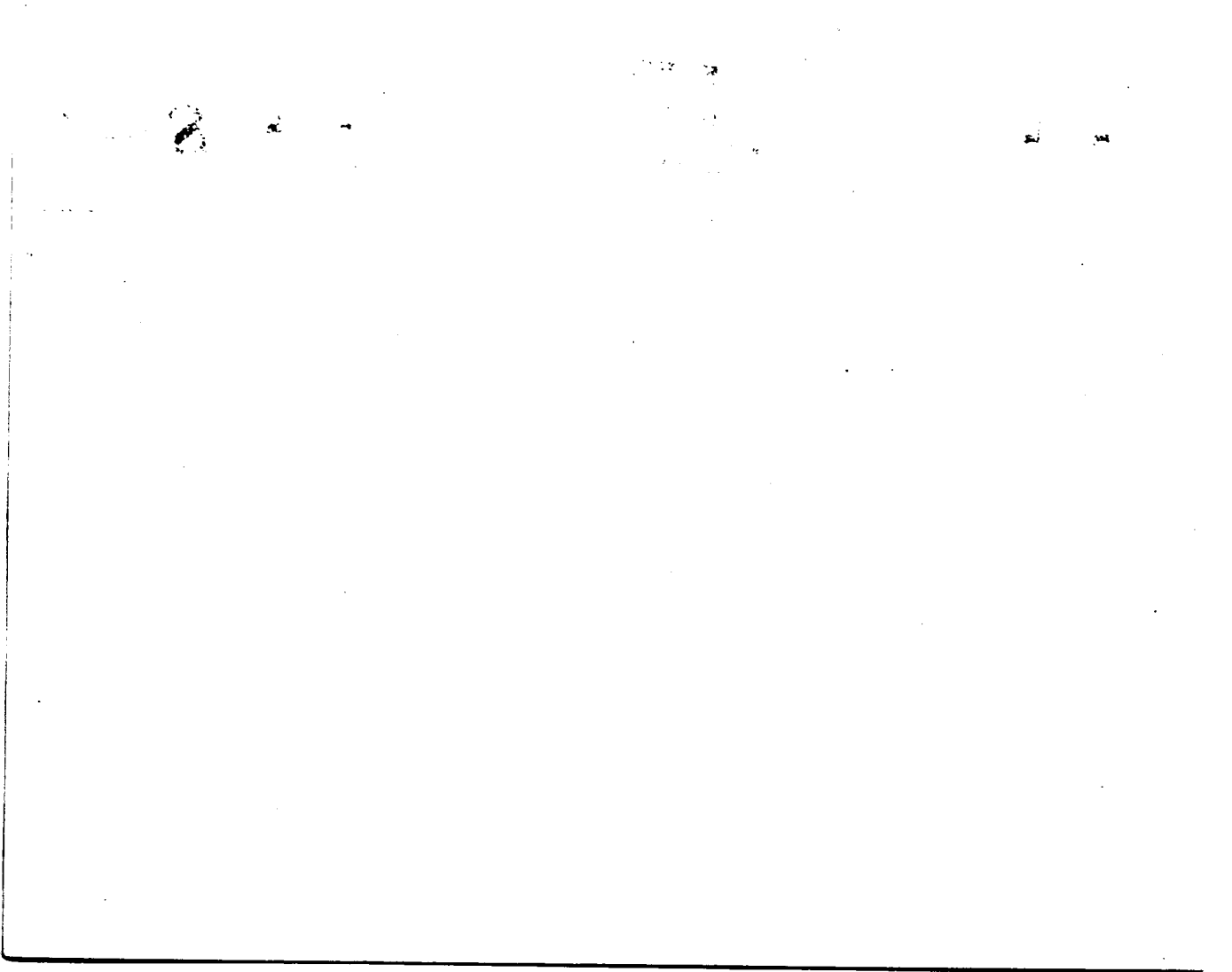
I hereby certify that I attended the birth of this child, who was still born at 10 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Horace P. Bellman
Nampa Ida.
(Physician or midwife)

Give names added from a supplemental report.
..... 19.....
.....
Registrar.

Address 107-12¹/₂ Ave. So.
Filed Oct 4 1923 Pearle Dodds
Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **43195**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Blaine*City of *Idaho Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Newcomb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Sept 20 1923

7. AGE

*11 yrs*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Oct 4 1923* *Pearl Dodds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 *20* *23*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1923 to *Sept 20 1923*
that I last saw him *in* *at* *11 AM*and that death occurred on the date stated above, at *11 AM*

The CAUSE OF DEATH* was as follows:

Stillborn
Rupture placental membrane
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Grace P. Belnap* M. D.(Address) *Nampa*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlstun, And *9-21-1923*

20. UNDERTAKER

ADDRESS

F. P. Robinson *Nampa*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

264225014962
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

115251

County of Canyon RECEIVED
City of Nampa OCT 6 1923
No. R# 2 BUREAU OF VITAL STATISTICS
Hospital _____ District No. 7 File No. [REDACTED]
Primary Registration District No. 2006 Registered No. _____
FULL NAME OF CHILD Stillborn Baughman
(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input checked="" type="checkbox"/> and <input checked="" type="checkbox"/> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Aug 25</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. 4 Number of child of this mother now living, including present birth. 3

FATHER		MOTHER	
FULL NAME	<u>George Baughman</u>	FULL MAIDEN NAME	<u>Elizabeth Robinson</u>
RESIDENCE	<u>R# 2 Nampa Ida</u>	RESIDENCE	<u>R# 2 Nampa Ida</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>41</u> (Years)	AGE AT LAST BIRTHDAY	<u>33</u> (Years)
BIRTHPLACE	<u>Penn.</u>	BIRTHPLACE	<u>Mo.</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born (Born alive or stillborn) M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Geo W Chilton

(Physician or midwife)

Give names added from a supplemental report.

Address Nampa Idaho

Filed Oct 4 1923 Pearle Sodds
Registrar.

Registrar.

2

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho Oct 22 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

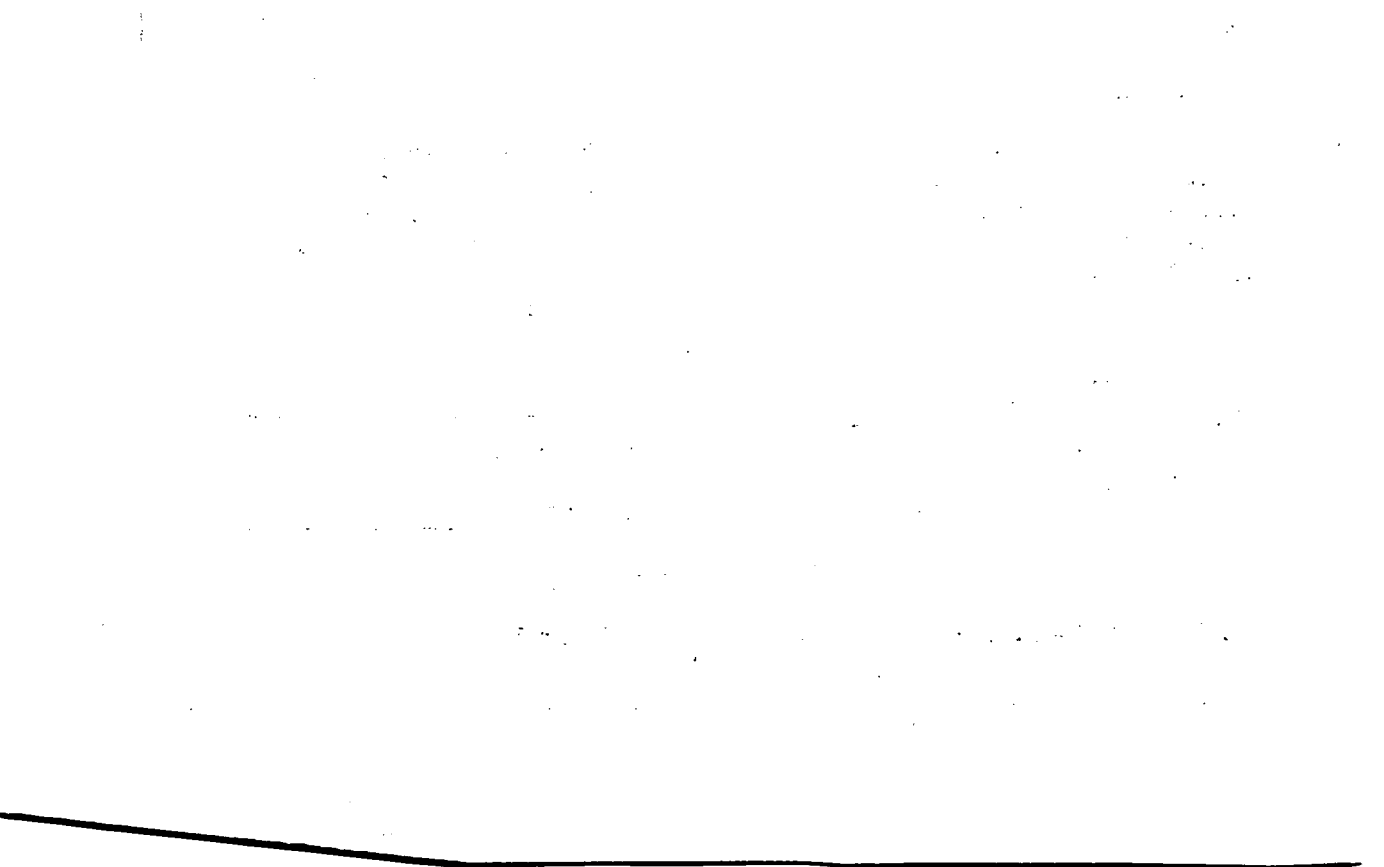
Place of Birth (CITY Manpa
 (ST. Rt. 2
 (COUNTY _____
 FATHER George F.

FILE NO. 115251
 DATE OF BIRTH Aug. 25 1923
 SEX OF CHILD Female
 MOTHER Elizabeth Roblin
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Was not named as it was a still Birth was
dead when born

Elizabeth Roblin
 Signature



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF Father

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filled

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25 1923 to Aug 25 1923

that I last saw her alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn infant
female cause unknown
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration)

ys. mos. ds.

(Signed)

Res W. Chilton

M. D.

19 (Address)

Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

945-205 014-249
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115252 S

County of Ad Canyon
City of Nampa

RECEIVED

OCT 6 1923

CERTIFICATE OF BIRTH

No. RR 2 St. Registration No. 7 State File No. 115252

BUREAU OF VITAL STATISTICS

Hospital _____ Primary Registration District No. 2006 Local Registrar's No. _____

FULL NAME OF CHILD Infant died 7/5/23
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>9</u> <u>5</u> <u>1923</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 7

FULL NAME <u>Robert R. Remister</u>	FATHER
RESIDENCE <u>Nampa Ida RR 2</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>California</u>	
OCCUPATION <u>farmer</u>	

FULL MAIDEN NAME <u>Sarah Smith</u>	MOTHER
RESIDENCE <u>Nampa RR 2</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { born alive } at _____ M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

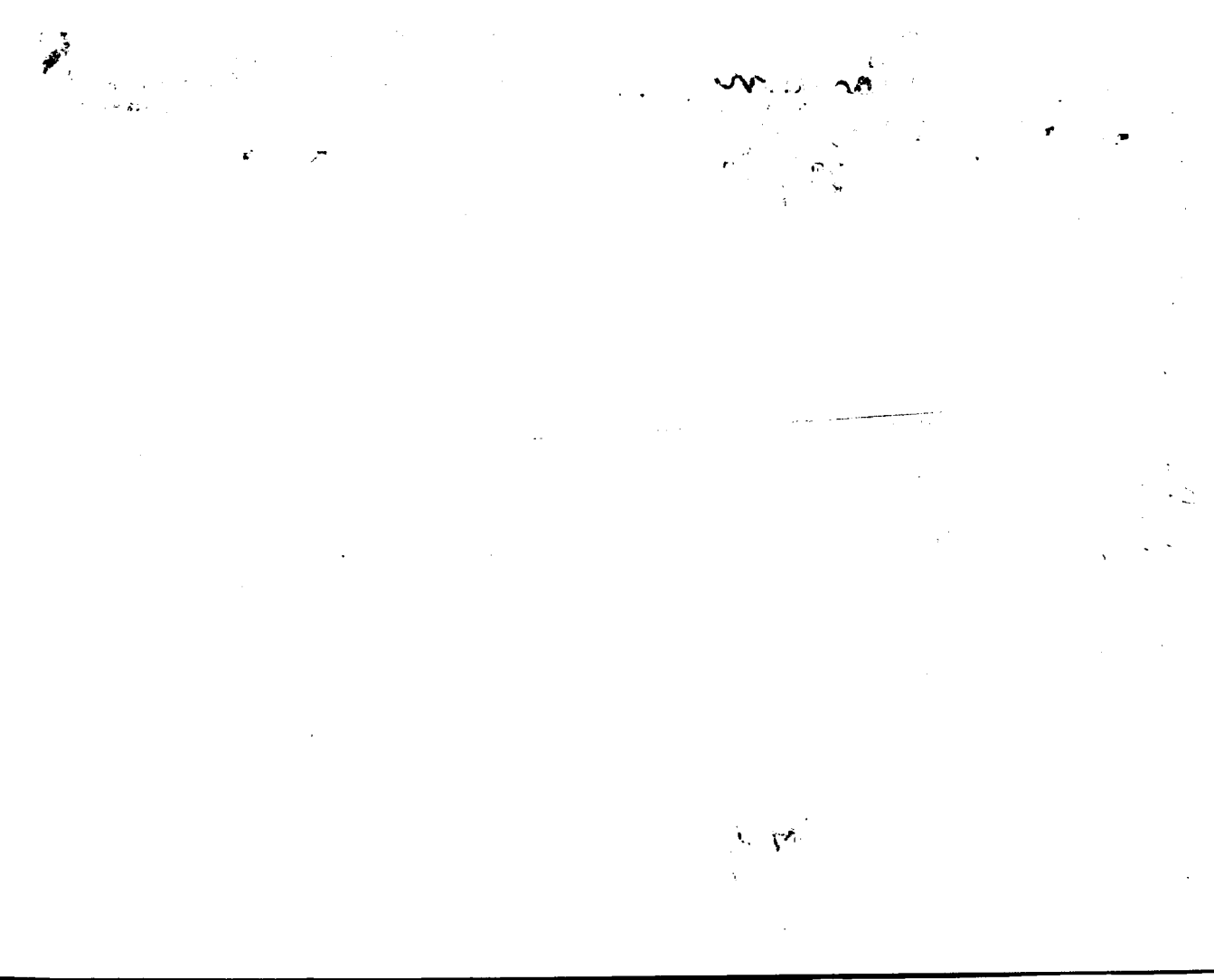
(Signature) N. F. Meaf
Physician
(Physician or midwife)

Address Mendian Idaho

Filed Oct 4 1923 Pearl Dods

Registrar.

Registrar.



STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho OCT 22, 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Hammer FILE NO. 115252
(ST. _____ DATE OF BIRTH Sept. 5
(COUNTY Canyon SEX OF CHILD Female
FATHER Robert W. Ray MOTHER Sarah E. Pernice
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

No name. Maid Sept. 3,

Sarah E. Pernice

Signature of Father or Mother

RECEIVED
OCT 27 1923
BUREAU OF VITAL
STATISTICS



CERTIFICATE OF DEATH

State of Idaho
BUREAU OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon District No. 1
City of Nampa Registration District No. 2006 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
OCT 6 1923
BUREAU OF VITAL STATISTICSnot named RummisterFile No. 43193
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

9 5 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nampa Idaho R 2

10. NAME OF FATHER

Robert R. Rummister

11. BIRTHPLACE OF FATHER

(State or Country)

Calif.

12. MAIDEN NAME OF MOTHER

Sarah Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Oct. 4 1923Pearle Dadds
Local Registrar

16. DATE OF DEATH

Several days before birth
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 9.15 19 23 to 9.15 19 23
did not see that I last saw h. alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

don't know
died in sleep(Duration) Yrs. about 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. F. Neal M. D.19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa

DATE OF BURIAL

9/15 19 23

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

366-120014-469
PLACE OF BIRTH

RECEIVED

OCT 6 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115265 S

County of Canyon

City of Nampa

No. _____ St. _____

Registration District No. _____

File No. _____

Hospital _____

Primary Registration District No. 1686

Registered No. _____

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child

Boy

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

Aug 20

1923

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? 1

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 2

FULL
NAME

Edgar Walter Cowley

FULL
MAIDEN
NAME

Florence Gertrude Morgan

RESIDENCE

Nampa

RESIDENCE

Nampa

COLOR

White

AGE AT LAST
BIRTHDAY

48
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

44
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Nampa

OCCUPATION

Carpenter

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Dr. M. S. Fink 10:1 P.
(Born alive or stillborn)

M.

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

Dr. M. S. Fink
Per M.B.
(Physician or midwife)

Give names added from a supplemental report.

_____, 19____

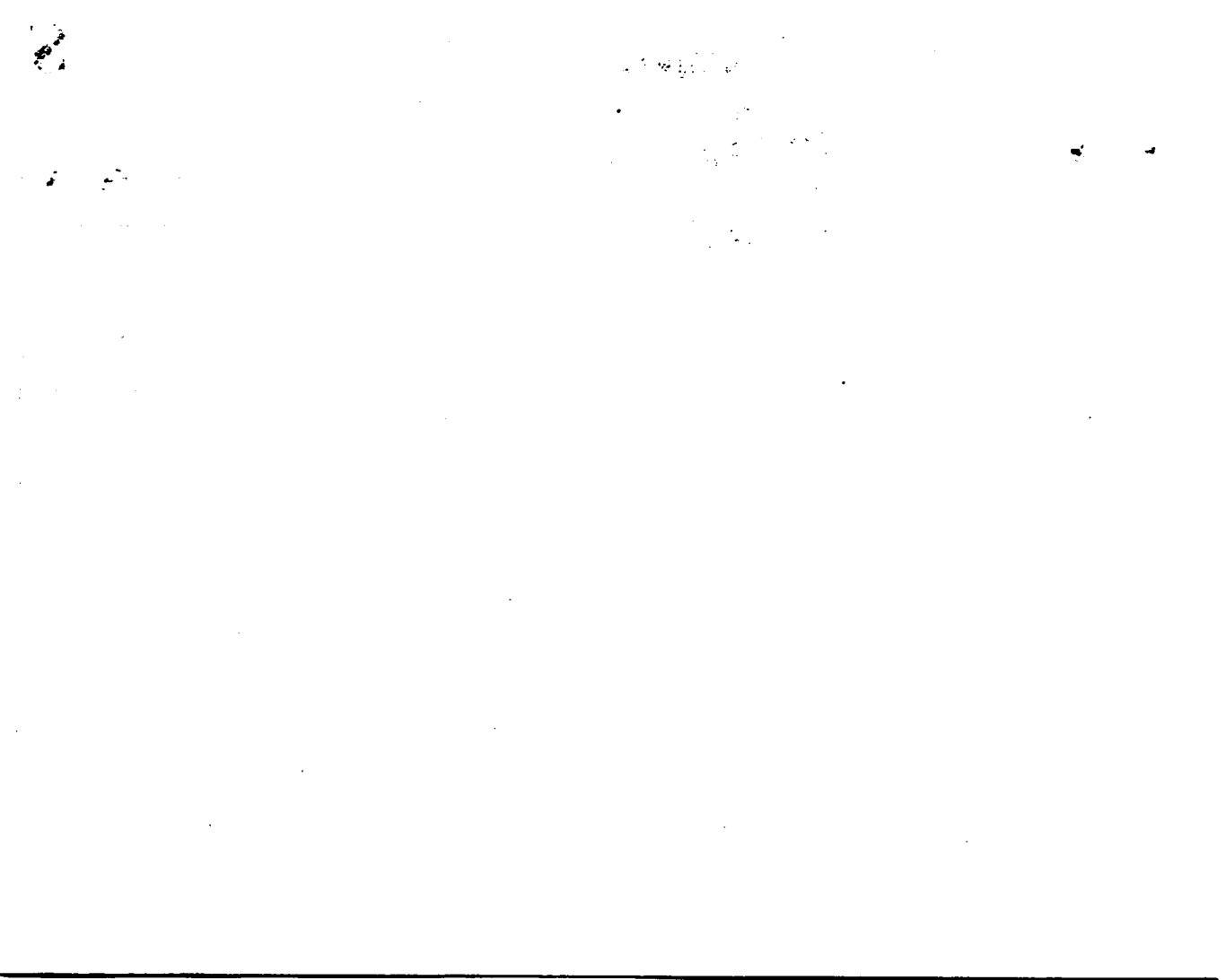
Address _____

Filed Oct. 4 1923

Pearle Dodds

Registrar.

Registrar.



RECEIVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon District No. 7
City of Nampa District No. 1806
If death occurs away from usual residence, give facts called for under special information.

State File No. 43183
Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

Aug. 20. 1923
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds. —

IF LESS than 1 day how many
hrs. or min.?
None

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nampa Ida.

10. NAME OF FATHER

Edgar Walter Cowley

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Florence Gertrude Morgan

13. BIRTHPLACE OF MOTHER

(State or Country)

Nampa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edgar W. Cowley

(Address)

Nampa Ida.

15.

Filed

Oct. 4 1923 Pearl Dodd

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 20. 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 20 1923 to Aug 20 1923

that I last saw him alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Monstrosity. Hydrocephalic.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

1923

(Address)

M. S. Cowley
Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa

DATE OF BURIAL

Aug 20 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework,** or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

789-225014-415
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115269 S

RECEIVED

OCT 6 1923

CERTIFICATE OF BIRTH

BUREAU OF VITAL STATISTICS

County of Canyon

City of Hamlet

No. _____ St. _____

Local District No. 7

File No. 115269

Hospital Mercy

Primary Registration District No. 1806

Registered No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>✓</u> and <u>✓</u> Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Aug 25</u> 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. _____ Number of child of this mother now living, including present birth. ✓

FATHER
FULL NAME T.C. Phillips
RESIDENCE Melba Ida
COLOR white AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Ill.
OCCUPATION Station Agent

MOTHER
FULL MAIDEN NAME Jean Slawson
RESIDENCE Melba, Ida
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Arkansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at _____ M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Geo. W. Chilton

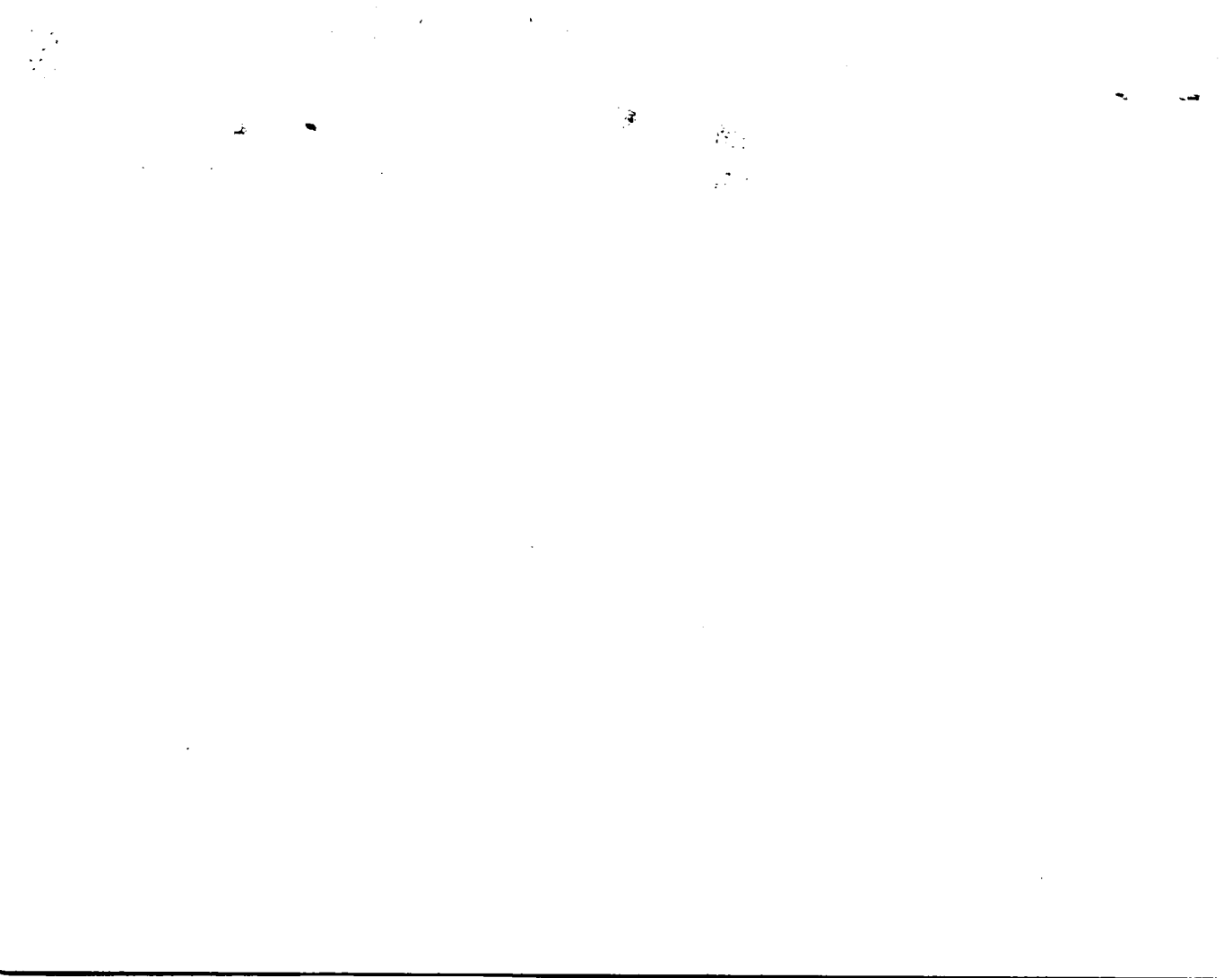
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Hamlet Ida
Filed Oct 4 1923 Pearl Dodds
Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 6 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **43188**
Registered No. _____

1. PLACE OF DEATH
County of Benewah Registration District No. 7
City of Hailey Registration District No. 2006 St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of J.C. Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Aug 26 1923
(Month) (Day) (Year)

7. AGE 1 Yrs. 1 Mos. 1 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER J. C. Phillips

11. BIRTHPLACE OF FATHER Shelby Co. Illinois
(State or Country)

12. MAIDEN NAME OF MOTHER Davidson

13. BIRTHPLACE OF MOTHER Sharp Co. Arkansas
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos C Phillips
(Address) Melba Idaho

15. Filed Oct 4 1923 Pearl Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 26 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1923 to Aug 26 1923
that I last saw him alive on 19
and that death occurred on the date stated above, at 10 M P
The CAUSE OF DEATH* was as follows:

Still born
Do not know cause.

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Horace P. Belting M. D.
9-17-23 (Address) Hailey

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Hailey DATE OF BURIAL Aug 26 1923
20. UNDERTAKER Frank J. Peterson ADDRESS Hailey

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

689-218 020-551
PLACE OF BIRTH

County of Elmore
City of Mtn. Home

No. _____ St. _____

Hospital _____

RECEIVED
SEP 29 1923
BUREAU OF VITAL
STATISTICS

Registration District No. 34

Primary Registration District No. 2020

S. No. 11-C-25m-7-21-19

115354 S

File No. _____

Registered No. 41

FULL NAME OF CHILD _____

Sex of Child Female Twin Triplet or other? _____ and _____ Number in order of birth _____ Legiti mate? yes Date of Birth Sept. 18 1923
(Month) (Day) (Year)

FATHER
FULL NAME Le Roy Dale White
RESIDENCE Mtn. Home Ida
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Kansas
OCCUPATION Harness Maker

MOTHER
FULL MAIDEN NAME Bertrude Eulene Evans
RESIDENCE Mtn. Home Ida
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Cottowood Ida
OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 1/2 Mo. 5-15 P.M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. C. P. Hamilton
Physician
(Physician or midwife)

Given names added from a supplemental report.

Address Mountain Home Ida
Filed Sept 28 1923 D. A. Zitting
Registrar

Registrar

2



1. PLACE OF DEATH

County of Elmore
 City of Mt Home

If death occurs away from usual residence, give facts calling for under special information.

2. FULL NAME

RECEIVED
 SEP 24 1923
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH
 Registration District No. 34
 Registration District No. 2110 St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 43219
 Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White (Write the word.)

6. DATE OF BIRTH

9 18 1923
 (Month) (Day) (Year)

7. AGE

Premature
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Mountain Home Ida.

10. NAME OF FATHER

L. D. White

11. BIRTHPLACE OF FATHER

(State or Country) Lenora, Norton Co Kan

12. MAIDEN NAME OF MOTHER

Gertrude E. Evans

13. BIRTHPLACE OF MOTHER

(State or Country) Cottonwood, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Mt Home Idaho

15.

Filed Sept 25 1923

D A Utter
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9-18 18 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-18 1923 to 19
 that I last saw her alive on at birth 9-18 1923
 and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Premature - 6 1/2 months.

(Duration) Yrs. mos. ds.
 Contributory Subject to mis carriage
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) A P Hamilton M. D.

9-18 1923 (Address) Mtn. Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt. Home Ida.

DATE OF BURIAL

9-18 1923

20. UNDERTAKER

Wm Mc Bratney

ADDRESS

Boise Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
862-125-021814
County of Franklin
City of Preston, Idaho.
No. _____ St. _____ Registration District No. 27 State File No. _____
Hospital *Mrs. Nancy Backstead* Primary Registration District No. 219 Local Registrar's No. 201
RECEIVED **CERTIFICATE OF BIRTH** 115372 S
OCT 9 1923
BUREAU OF VITAL STATISTICS
FULL NAME OF CHILD *Bert Johnson (Stillborn)*
(Certificate of no value without full name of child.)

Sex of Child Male	Twin Triplet or other? and { Number in order of birth 1 }	Legitimate? Yes	Date of birth Sept. 25 , 1923 (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5	Number of child of this mother now living, including present birth 2
FULL NAME Jessie V. Hobson	FULL MAIDEN NAME Annie Hadley
RESIDENCE Oxford, Idaho.	RESIDENCE Oxford, Idaho.
COLOR White AGE AT LAST BIRTHDAY 33 (Years)	COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Oxford, Idaho.	BIRTHPLACE Brian City, Utah.
OCCUPATION Farmer	OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *Caesarean Section*

I hereby certify that I attended the birth of this child, who was *Stillborn* at _____ M.

When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1923

(Signature) *G. W. State*
Physician
(Physician or midwife)
Address **Preston, Idaho.**

Filed *Oct 3* 1923 *Mrs. Ida Lippert*
Registrar.

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho OCT 22 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place (CITY Preston
of (ST. Ida
Birth (COUNTY Franklin
FATHER J V Hobson

FILE NO. 115372
DATE OF BIRTH Sept 25 1923
SEX OF CHILD Male
MOTHER Annie Sophronia Hadley
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Bert Hobson

(Stillborn)

Jesse Ver Hobson

Signature of Father or Mother

RECEIVED
22 1923
VITAL

MAR 9 1964

1. PLACE OF DEATH

County of Franklin

City of Arreston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Hobson

CERTIFICATE OF DEATH

RECEIVED
OCT 9 1923
BUREAU OF VITAL STATISTICS

Registration District No. 27

Primary Registration District No. 2119

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43223

Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH

September 25, 1923. 1
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Arreston, Idaho.

10. NAME OF FATHER

Jesse Var Hobson,

11. BIRTHPLACE OF FATHER

(State or Country) Oxford, Idaho.

12. MAIDEN NAME OF MOTHER

Annie Hadley,

13. BIRTHPLACE OF MOTHER

(State or Country) Brigham City, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. V. Hobson

(Address) Oxford, Ida.

15.

Filed Oct 3 1923

Local Registrar Mrs. H. L. Taylor

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 25, 1923. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 25, 1923 to Sept 25, 1923
that I last saw h. still born 19
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Child found in abdominal cavity after ruptured uterus. Removed by Caesarian section.
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) E. W. States M. D.

Sept. 25, 1923 (Address) Arreston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Lake, Idaho. Sept. 26, 1923.

20. UNDERTAKER

Address Arreston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

444-210-028-466
PLACE OF BIRTH

RECEIVED

OCT 10 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115475

County of *Bostune*City of *Sevier d'Alene*Registration District No. *30*File No. *115475*

No. _____ St. _____

Primary Registration District No. *1057* Registered No. *1641*

Hospital _____

FULL NAME OF CHILD *Beverly Lou Mudge*Sex of Child *Female*Twin
Triplet
or other?

and

Number
in order
of birthLegiti-
mate?Date of
Birth

(Month)

(Day)

1923

(Year)

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth *3* Number of children of this mother now living, including present birth *2*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

(Born alive or stillborn)

(Physician or midwife)

Given names added from a supplemental report.

Address

Filed

Registrar.

Registrar.

STATE OF IOWA
OF THE
JURY

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho OCT 22 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Coeur d'Alene FILE NO. 115475
 (ST. 623 Sherman DATE OF BIRTH Sept 10 - 1923
 (COUNTY Bozeman SEX OF CHILD Female
 FATHER Wm Mudge MOTHER Lella Downs
 (Maiden Name)

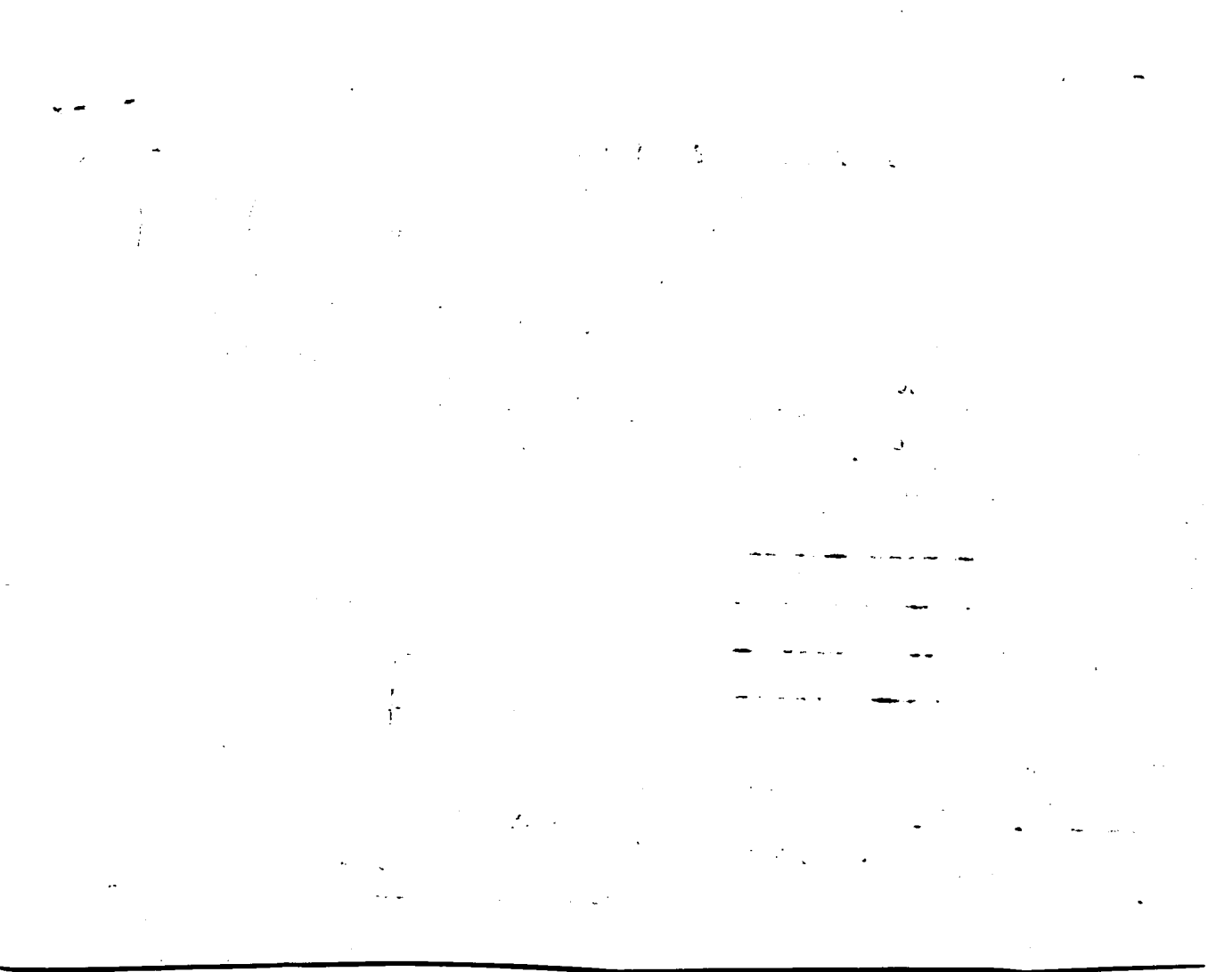
I HEREBY CERTIFY that the child herein described has been named:

Beverly Lou Mudge

Wm Mudge

Signature of Father or Mother.

RECEIVED
 1 1923
 OF VITAL
 STATISTICS



1. PLACE OF DEATH

County of *Boonville*City of *Boonville*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Unmarried, Wm. Mudge

CERTIFICATE OF DEATH

Registration District No. *30*Registration District No. *10541*

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *43264*Registered No. *1325*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

9 *10* *1923*
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*None*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William Mudge

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Bella Mudge

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Wm. Mudge
Boonville, Idaho*

15.

Filed *Oct 11* *1923**1923**W. H. D. Dunning*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 *10* *1923*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 10 *1923* to *Sept. 10* *1923*that I last saw him alive on *1923*and that death occurred on the date stated above, at *7* M.

The CAUSE OF DEATH* was as follows:

*Asphyxia neonatorum.**Shoulder circumference 17"*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John O. Wood M. D.*Boonville, Idaho* (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Low Cemetery, Boonville, Idaho**9.11.1923*

20. UNDERTAKER

ADDRESS

E. L. Cassidy *Boonville*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

816-219 029-236
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115499 S

County of Latah
City of Pattatah
No. 77 St. Registration District No. 60 State File No. 119099
Hospital 77 Primary Registration District No. 2145 Local Registrar's No. _____

FULL NAME OF CHILD Edna Ous Hauge
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 19 -</u> , 192 <u>3</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? 10. Regard

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME <u>Eduard Hauge</u>	FULL MAIDEN NAME <u>Hanna Starnick</u>	FULL NAME <u>Eduard Hauge</u>	FULL MAIDEN NAME <u>Hanna Starnick</u>
RESIDENCE <u>Pattatah</u>	RESIDENCE <u>Pattatah</u>	RESIDENCE <u>Pattatah</u>	RESIDENCE <u>Pattatah</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Norway</u>	BIRTHPLACE <u>Norway</u>	BIRTHPLACE <u>Norway</u>	BIRTHPLACE <u>Norway</u>
OCCUPATION <u>Mill Hand</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Mill Hand</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 P. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. Gibson
Physician
(Physician or midwife)

Address Pattatah

Filed Aug 29, 1923 D. J. Thompson
Registrar.

Trial	Control (n = 10)	MCI (n = 10)	AD (n = 10)
1	95	85	75
2	95	85	75
3	95	80	70
4	95	75	65
5	95	75	65

1. 2. 3. 4.

295-203 035-659
PLACE OF BIRTHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

115625

CERTIFICATE OF BIRTH

County of My PerceCity of Lewiston

No. _____ St. _____

Registration District No. 96File No. 115625

Hospital _____

Primary Registration District No. 1099

Registered No. _____

FULL NAME OF CHILD William Sinclair

(Certificate of no value without full name of child.)

Sex of Child femaleWas
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth 7Legiti-
mate? yesDate of
birth 9 3
(Month) (Day)1923
(Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 7Number of child of this mother now living, including present birth 6FULL
NAME

FATHER

Joseph Elmer Sinclair

RESIDENCE

Lewiston Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY 48
(Years)

BIRTHPLACE

MO

OCCUPATION

LaborerFULL
MAIDEN
NAME

MOTHER

Laura Ida Funderud

RESIDENCE

Lewiston Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY 38
(Years)

BIRTHPLACE

Washington

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born dead on the date above stated.8:30 at PM M.
(Born alive or stillborn)

When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. F. Dorman M.D.

(Physician or midwife)

Give names added from a supplemental report.

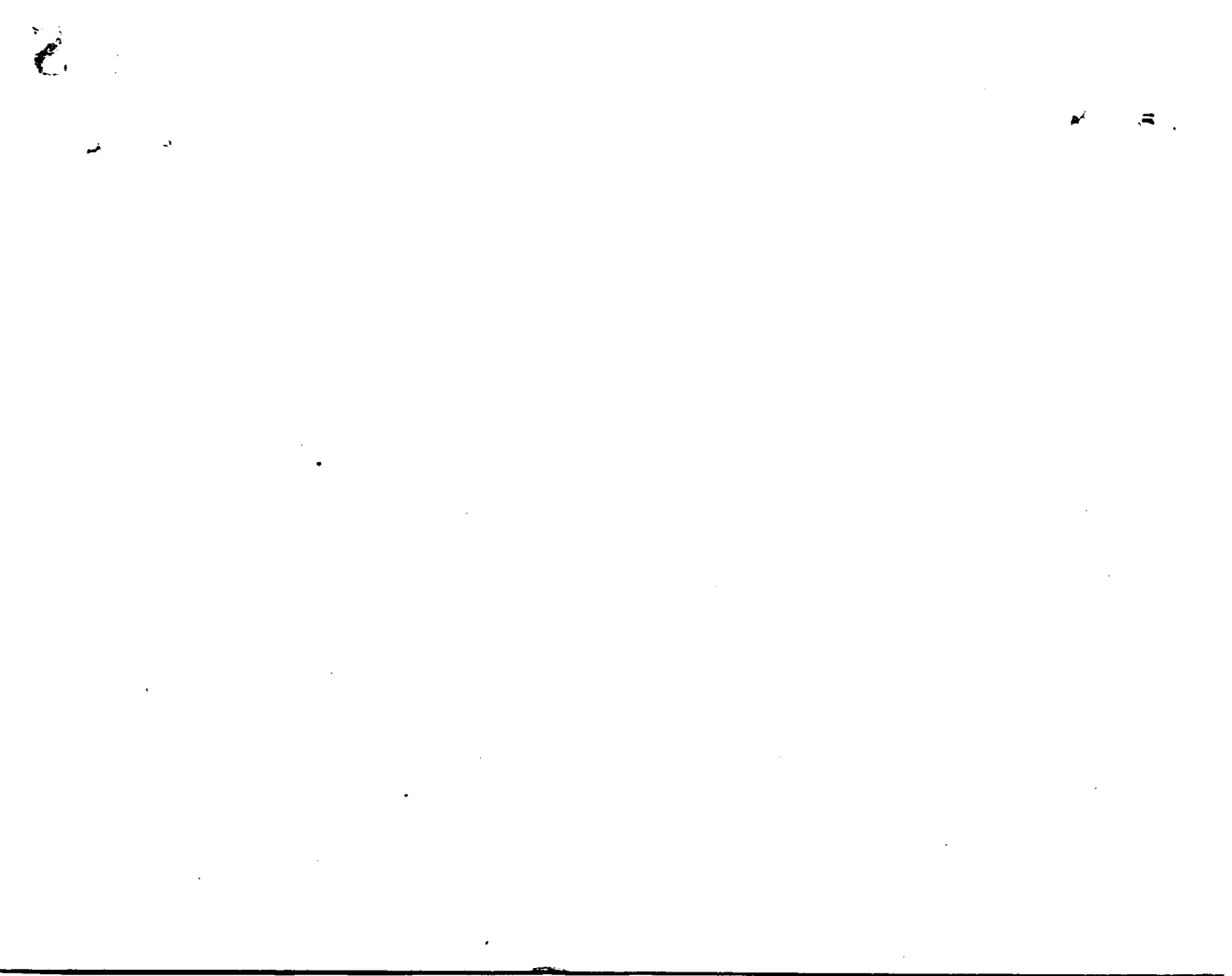
Address Lewiston IdahoFiled Oct-6

1923

Ernest E. Bruce

Registrar.

Registrar.



RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1923

Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

.....19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coeur d'Alene Idaho Sep 3 1923

20. UNDERTAKER

ADDRESS

Vassar Underbrink Co. Coeur d'Alene Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. H.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

331 104 042-168
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of *Iron*

OCT 4 1923

CERTIFICATE OF BIRTH

115722

City of *Buhl*

BUREAU OF VITAL

No. _____ St. _____

Registration District No. _____

State File No. _____

Hospital _____

Primary Registration District No. *2087*

Local Registrar's No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <i>Male</i>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and {	Number in order of birth _____	Legitimate? <i>Yes</i>	Date of birth <i>9-4-</i> 192 <i>3</i> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth <i>6</i>		Number of child of this mother now living, including present birth <i>5</i>	
FULL NAME <i>Arthur Clark</i>	FATHER	FULL MAIDEN NAME <i>Alice Johnson</i>	MOTHER
RESIDENCE <i>Buhl, Ida.</i>		RESIDENCE <i>Buhl, Ida.</i>	
COLOR <i>wh</i>	AGE AT LAST BIRTHDAY <i>40</i> (Years)	COLOR <i>wh</i>	AGE AT LAST BIRTHDAY <i>40</i> (Years)
BIRTHPLACE <i>Mo.</i>		BIRTHPLACE <i>Nor. Cal.</i>	
OCCUPATION <i>Farmer</i>		OCCUPATION <i>Housewife</i>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *born alive* at *R. P.* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) *Dr. J. H. Murphy*

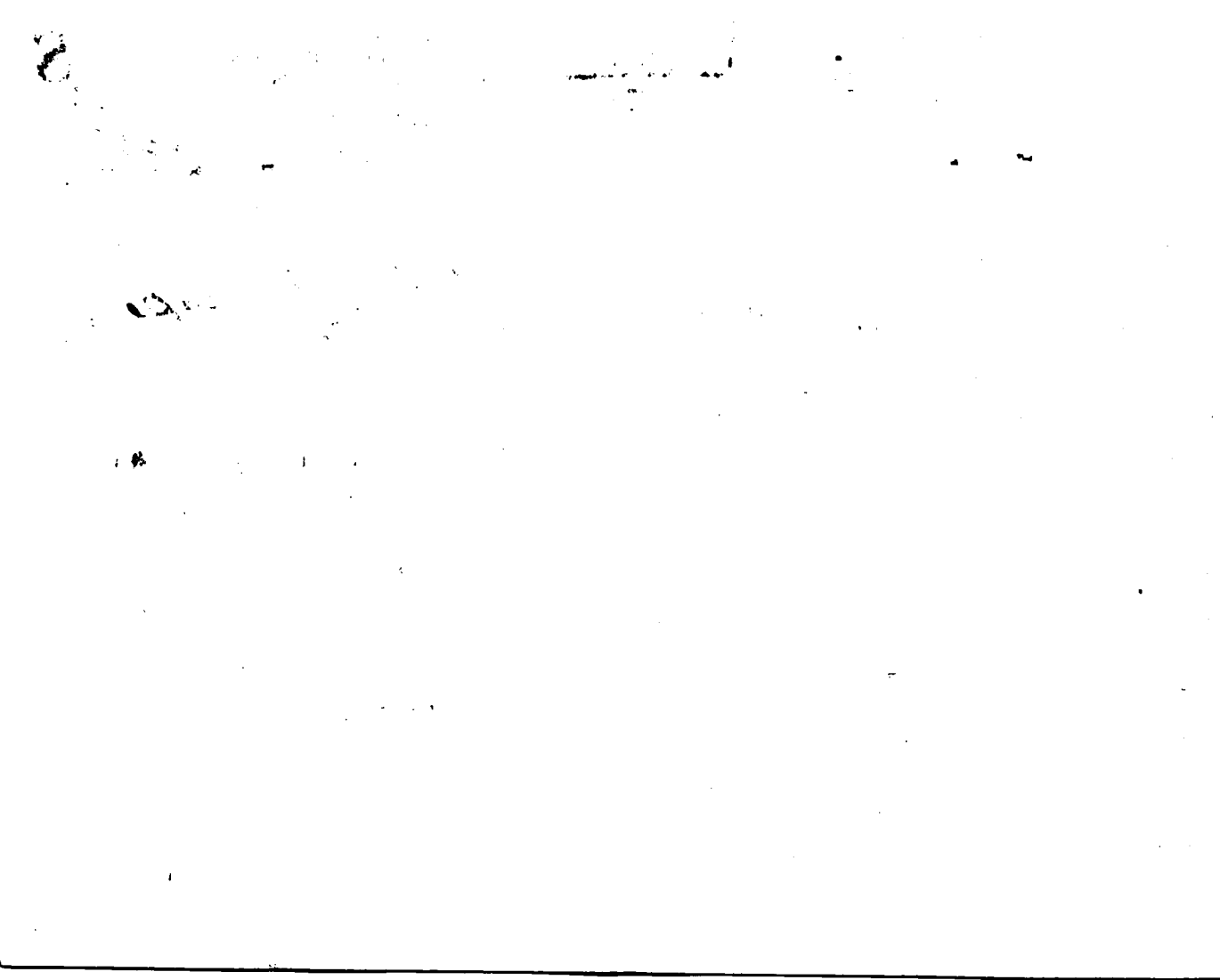
(Physician or midwife)

Address *Buhl, Ida.*

Filed *SEP 30 1923*

Registrar.

Registrar.



OCT 4 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*
City of *Buhl*

BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No. *20187*
(No. *39* St.)File No. *43356*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *Wht* *(Write the word.)*

6. DATE OF BIRTH

9-4-1923
(Month) (Day) (Year)

7. AGE

2 Yrs. *2* Mos. *2* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*none*

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Arthur Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Alice Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Nor. Car.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Clark

(Address)

Buhl, Ida.

15.

Filed *Sept 4* 19*23**J. H. Murphy*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn- 9-4-23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-4-23 to *9-4-1923*that I last saw him *alive* on *9-4-1923*and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

*Stillborn. Partly macerated
fetus. Death apparently occurred
2 or 3 wks. previous to delivery.
No parental prenatal history.*Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. Jennings M. D.*9-4-23* (Address) *Buhl, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

At home 4 W. 14. Buhl *9-4-23*

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED
NOV 7 1923

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Moreland

No. 255-19-2616557 St.

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

115966

Registration District No. 121

State File No.

Hospital

Primary Registration District No. 2194

Local Registrar's No. 378

FULL NAME OF CHILD

Shelburn

Benson

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

4 and

{ Number
in order
of birth

5

Legiti-
mate?

yes

Date of
birth

Oct 19

1923

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

9

Number of child of this mother now living, including present birth

7

FULL
NAME

FATHER

H Andrew Benson

RESIDENCE

Moreland

COLOR

White

AGE AT LAST
BIRTHDAY

44
(Years)

BIRTHPLACE

Denmark

OCCUPATION

County Clerk

FULL
MAIDEN
NAME

MOTHER

Ida England

RESIDENCE

Moreland

COLOR

White

AGE AT LAST
BIRTHDAY

41
(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

W W Beck

(Physician or midwife)

Address

Blackfoot, Idaho

Filed

Nov. 3 1923

Registrar.

Registrar.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham
City of Morland

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr named Benson

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 2194

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 43411Registered No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single
(Write the word.)

6. DATE OF BIRTH

October 19 1913
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. Andrew Benson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Ida England

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Benson

(Address)

Morland 2nd

15.

Filed

Oct 22 1913 Mr. Walter P. Paine

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn Oct 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

B. Stillborn 19
that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Premature detachment of placenta
(Duration)..... Yrs. mos. ds.Contributory.
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)

W. W. Beck M. D.10/20 1913 (Address) Blackfoot 24

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morland, Ida19

20. UNDERTAKER

ADDRESS

acting = H. Benson Morland

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

497-207-236-234

County of *Lincoln*City of *Blackfoot*No. *7* St. *Pine*

RECEIVED

NOV 7 1923

BUREAU OF VITAL STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

Registration District No. *121*State File No. *116004*Hospital..... Primary Registration District No. *1007* Local Registrar's No. *363*

FULL NAME OF CHILD

Van Clara Nixon

(Certificate of no value without full name of child.)

Sex of Child <i>Female</i>	Twin Triplet or other? <i>No</i>	and Number in order of birth <i>1</i>	Legitimate? <i>Yes</i>	Date of birth <i>Oct. 7, 1923</i>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth..... Number of child of this mother now living, including present birth.....

FATHER
FULL NAME *John Singleton Nixon*RESIDENCE *Blackfoot Idaho*COLOR *White* AGE AT LAST BIRTHDAY *36* (Years)BIRTHPLACE *Kansas*OCCUPATION *Auto Salesman*MOTHER
FULL MAIDEN NAME *Ruth Van Haren*RESIDENCE *Idaho*COLOR *White* AGE AT LAST BIRTHDAY *26* (Years)BIRTHPLACE *Idaho*OCCUPATION *Housewife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *stillborn* at *10 P.* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *W. E. Patrie M.D.*

(Physician or midwife)

Give names added from a supplemental report.

Address *Blackfoot Idaho*Filed *Nov. 5 1923* *Wm. H. Lee E. Patrie*

Registrar.

Registrar.

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

NOV 15 1923

Boise, Idaho _____ 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Blackfoot FILE NO. 116004
 (ST. North Pine DATE OF BIRTH October 7, 1923
 (COUNTY Bingham SEX OF CHILD Female
 FATHER John S. Dixon MOTHER Arth Van Blaricom
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

RECEIVED Van Ora Dixon

NOV 24 1923

BUREAU OF VITAL
STATISTICS

Mr. J. S. Dixon

Signature of Father or Mother.

U.S. DEPARTMENT OF JUSTICE
BUREAU OF PRISONS

1928. _____, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of course important to have the full name included in the record. Kindly fill in the information requested in the blank below and return it to the Bureau of Prisons. The enclosed self-addressed envelope will be used for the return of the certificate.

NAME OF CHILD		DATE OF BIRTH		PLACE OF BIRTH	
_____		_____		_____	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION	
_____		_____		_____	
MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION	
_____		_____		_____	

(Signed Name)

I HEREBY CERTIFY that the child herein described has been born to _____

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **43405**Registered No. **114**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **121**
County of **Blaine** Primary Registration District No. **1007**
City of **Blackfoot** St. **North Pine**

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME **Unnamed Person**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **(Write the word.)**

6. DATE OF BIRTH

Oct 7 1923
(Month) (Day) (Year)

7. AGE

NoIF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**None**

9. BIRTHPLACE

(State or Country)

Blackfoot Idaho

10. NAME OF FATHER

John Singleton Dixon

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ruth Van Blaricom

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blackfoot Idaho

15.

Filed

Oct 9 1923**M. H. E. Putnam**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 7 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 7 1923 to **Oct 7 1923**
that I last saw him alive on **10 P.M.**and that death occurred on the date stated above, at **10 P.M.**

The CAUSE OF DEATH* was as follows:

Stillborn 6 months due to 694 miles auto ride from Denver
(Duration) Yrs. mos. ds.

Contributory (Secondary)

Spina bifida

(Duration) Yrs. mos. ds.

(Signed)

M. E. Patric M. D.

19

(Address) **Blackfoot Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Van Blaricom place**Oct 8 1923**

20. UNDERTAKER

ADDRESS

Blackfoot Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

362-122-006-692
PLACE OF BIRTH

RECEIVED
NOV 7 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham
City of Blair
No. _____ St. _____
Registration District No. 121

File No. 116011

Hospital _____ Primary Registration District No. 1007 Registered No. 332

FULL NAME OF CHILD

Temp Cosgrove
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth... <u>4-22</u> ...192 <u>3</u> (Month) (Day) (Year)
-----------------------------	---	-----	--------------------------------	--------------------------------	---

What bacteriocidal solution was used in eyes? X

Number of child of this mother, including present birth...7 Number of child of this mother now living, including present birth...5

FATHER
FULL NAME Sam Cosgrove
RESIDENCE Blairfoot Ida
COLOR Indian AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Myr
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Nancy Wiskorp
RESIDENCE Blairfoot Ida
COLOR Indian AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 8 P. M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. O. Hampton
(Physician or midwife)

Give names added from a supplemental report.

Address Blairfoot Ida
Filed Nov. 5 1923 Mr. Helen E. Talbot
Registrar.

2

Handwritten mark, possibly "P" or "B".

703

dup of 1923-136042

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho NOV 15 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

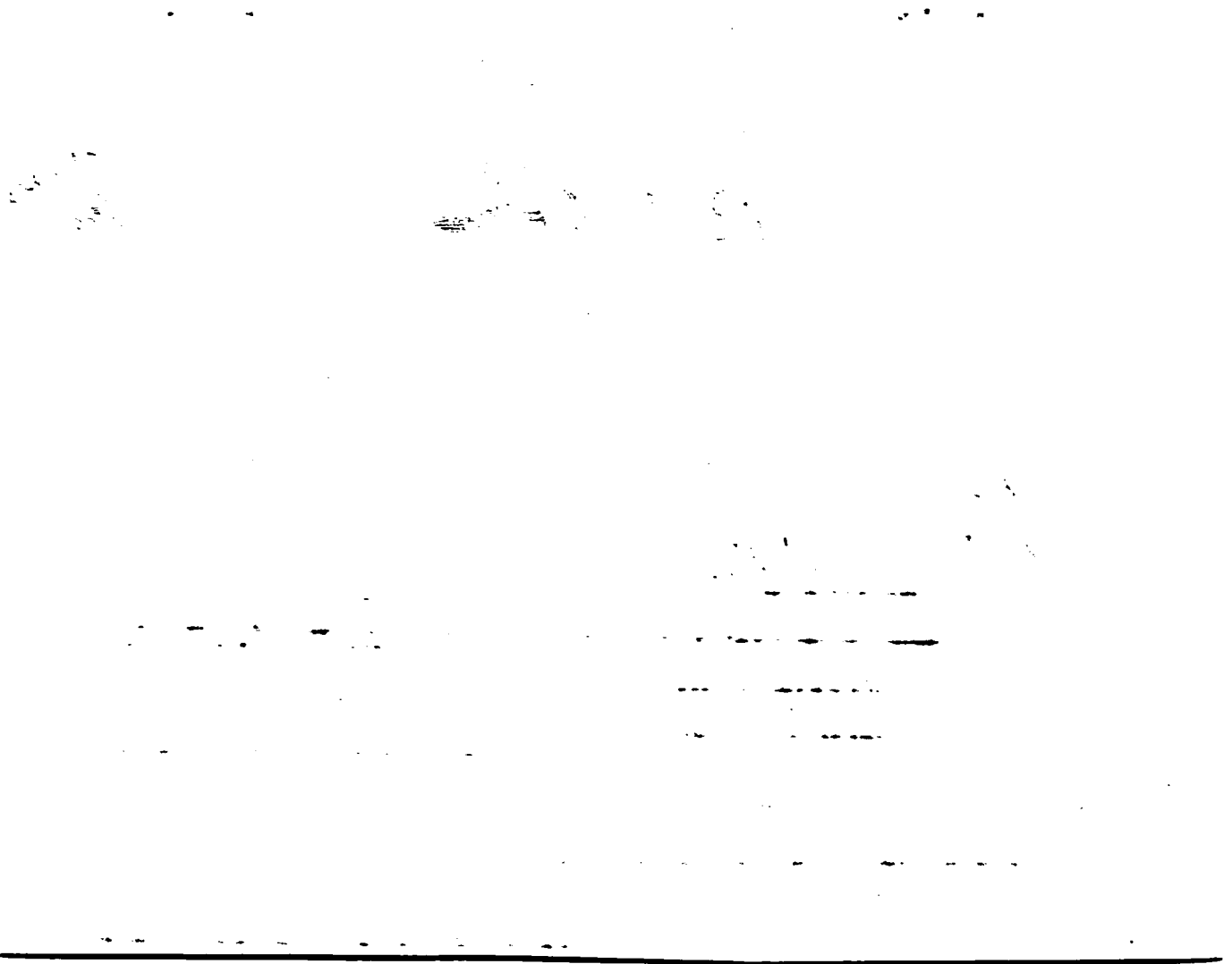
* * * * *

Place of Birth (CITY Blackfoot
ST. West Judicial
COUNTY Bingham
FATHER T.K. Corrigan
FILE NO. 116011
DATE OF BIRTH Sept 22, 1923.
SEX OF CHILD Male
MOTHER Nancy Wishope
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Tempe Corrigan

T.K. Corrigan



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
50967

1 PLACE OF DEATH County <u>Blaine</u> State <u>Idaho</u> City or Village <u>Blackfoot</u> No. _____ St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number)		2 FULL NAME <u>Manuel Casgove</u>	
(a) Residence. No. _____ St. _____ Ward _____ (Usual place of abode) Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If nonresident give city or town and State)			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Ind. 3/4</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>	
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____			
6 DATE OF BIRTH (month, day, and year) <u>Sept. 22-1923</u>			
7 AGE	Years <u>0</u>	Months <u>0</u>	Days <u>0</u> If LESS than 1 day, — hrs. or — min.
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			
9 BIRTHPLACE (city or town) <u>Blackfoot</u> (State or country) <u>Idaho</u>			
10 NAME OF FATHER <u>Tom Casgove</u>			
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>Wyoming</u>			
12 MAIDEN NAME OF MOTHER <u>Nancy Wickup</u>			
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>St. Hall Reservation</u>			
14 Informant <u>Tom Casgove</u> (Address) <u>Blackfoot, Idaho</u>		15 Filed _____, 19 _____ REGISTRAR	
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH (month, day, and year) <u>Sept. 22 1923</u>			
17 Attended by <u>Dr. J. O. Hamilton, Blackfoot, Id.</u> I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at <u>9 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Stillborn at term</u> (duration) _____ yrs. _____ mos. _____ ds. CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds. 18 Where was disease contracted _____ If not at place of death? _____ Did an operation precede death? <u>No</u> Date of _____ Was there an autopsy? <u>No</u> What test confirmed diagnosis? <u>None</u> (Signed) <u>Henry R. Thulius</u> , M. D. (Address) <u>J. H. Hall, Idaho</u> * State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)			
19 PLACE OF BURIAL, CREMATION, OR REMOVAL <u>St. Hall Reservation</u>		DATE OF BURIAL <u>Sept 23 1923</u>	
20 UNDERTAKER <u>Brown & Eldredge</u>		ADDRESS <u>Blackfoot Idaho</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death)*, 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hemorrhage," "Intoxication," "Marasmus," "Old age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

296 119 007 243
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine
City of Hailey
No. 57
St. St.

RECEIVED
NOV 13 1923
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

Hospital St. Registration District No. 2022 File No. 116030
Registered No. 64

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>9 19 1923</u> (Month) (Day) (Year)
--------------------------	----------------------------------	---------------	------------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? X

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME FATHER
Walter Brown
RESIDENCE Gannett, Ida
COLOR white AGE AT LAST BIRTHDAY 46 (Years)
BIRTHPLACE Scotland
OCCUPATION Farmer

FULL MAIDEN NAME MOTHER
Mary Sullivan
RESIDENCE Gannett, Ida
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Ireland
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

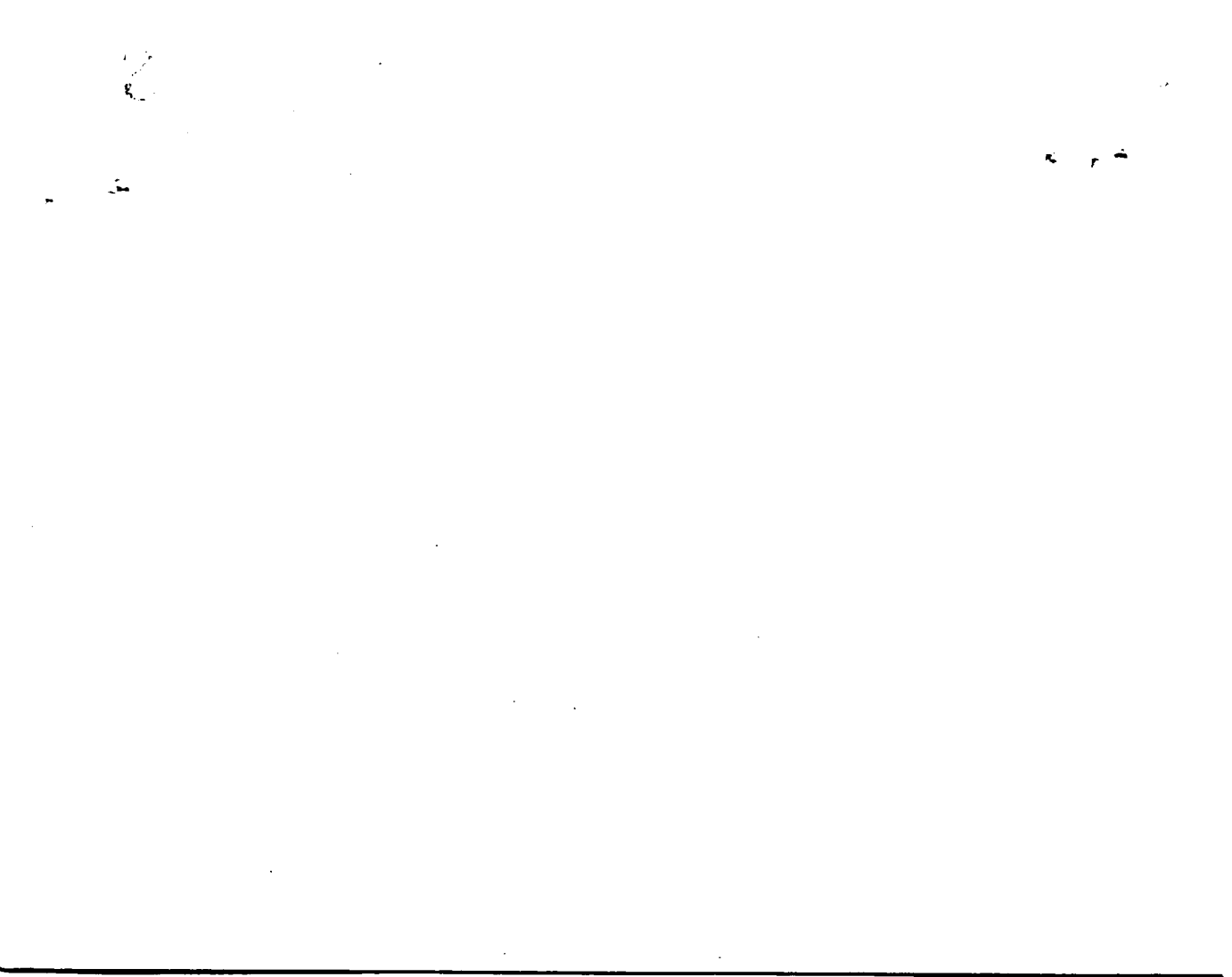
I hereby certify that I attended the birth of this child, who was Stillborn at 1:30 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Robert H. Wright M.D.
(Physician or midwife)

Give names added from a supplemental report.
....., 19.....
Registrar.

Address Hailey, Ida
Filed 9-20 1923 Robert H. Wright
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 57
County of Blaine Primary Registration District No. 2022
City of Hailey BUREAU OF VITAL STATISTICS St. Registered No. 43422

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Sept. 19, 1923
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Hailey Idaho.

10. NAME OF FATHER

Walter Brown.

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland.

12. MAIDEN NAME OF MOTHER

Mary Sullivan.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Walter Brown
Gannett, Idaho.

15.

Filed

Oct 1, 1923

W. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 19, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 191 to ✓ 191
that I last saw him alive on ✓ 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.

9/20/23 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey Ida.
Oct 20, 1923.
20. UNDERTAKER
A. J. Harris
ADDRESS
Hailey

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

314-229 009 264
PLACE OF BIRTH

RECEIVED

NOV 10 1923

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Sandpoint

No. 1 Millton St.

BUREAU OF VITAL
STATISTICS

Registration District No. 76

File No. 116054

Hospital

Primary Registration District No. 2155

Registered No.

FULL NAME OF CHILD

Janner

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>10-29</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes?.....

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME John Melson Janner
RESIDENCE Sandpoint
COLOR white AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Canada
OCCUPATION Millwright

MOTHER
FULL MAIDEN NAME Emma May Somerville
RESIDENCE Sandpoint
COLOR white AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Amber - Mich.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. P. Stackhouse
M.D.
(Physician or midwife)

Give names added from a supplemental report.
....., 19.....
.....
Registrar.

Address Sandpoint
Filed Nov 3 1923 Viola Allen
Deputy Registrar.

2

DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

116024

File No.

Registration District No.

Registration No.

Primary Registration District No.

(To be filled in by the registrar at the time of registration)

Place of birth	Sex	Color	Date of birth

Number of children of this mother now living, including present birth

MOTHER	FULL NAME	MAIDEN NAME

DATE AT LAST BIRTHDAY	COLOR

BIRTHPLACE	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Signature of attending physician or midwife

Signature of registrar	Signature of attending physician or midwife

Address	City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Bonner*
City of *Sandpoint*Registration District No. *78*Primary Registration District No. *2155*
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant Tanner.*State File No. *43431*

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Oct. 29, 1923.
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many
____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Infant.*

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF Father

John Tanner.

11. BIRTHPLACE OF FATHER

(State, or Country)

Canada.

12. MAIDEN NAME OF MOTHER

Mae Hammerville

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Tanner

(Address)

Sandpoint Idaho

15.

Filed

*Oct 30*19*23**Viola Allen**Deputy* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 29, 1923.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____ to 19____,

that I last saw him alive on 19____,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Death in utero.**Eighth month.**Slight skin maceration.*
Probable Cause - Habit. (3rd)
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *C. P. Stackhausen, M. D.*10/30/23 (Address) *Sandpoint, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. ds.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Spreen Cemetery

DATE OF BURIAL

10/30 1923

20. UNDERTAKER

L. H. Moon

ADDRESS

Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

464 130-009-389
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

NOV 10 1923

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

City of Sandpoint

No. 424 Superior St.

Registration District No. 76

File No. 116056

Hospital Lancaster

Primary Registration District No. 2155

Registered No. Wadd

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of
Child male

☒ Twin
☐ Triplet
or other?

and

Number
in order
of birth 2

Legiti-
mate? yes

Date of
birth Oct 30 1923

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 3...

Number of child of this mother now living, including present birth... 2...

FULL
NAME

FATHER

Albert E. Wadd

RESIDENCE

Granite

COLOR

White

AGE AT LAST
BIRTHDAY 3.5

(Years)

BIRTHPLACE

Clinton, Iowa

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Maryle L. M. Chilcote

RESIDENCE

Granite, Ida

COLOR

White

AGE AT LAST
BIRTHDAY 27

(Years)

BIRTHPLACE

Dover, Missouri

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... still born... at... 6:15 P. M.
on the date above stated.

(Born alive or stillborn)

* When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) Floyd G. Sandle

(Physician or midwife)

Give names added from a supplemental report.

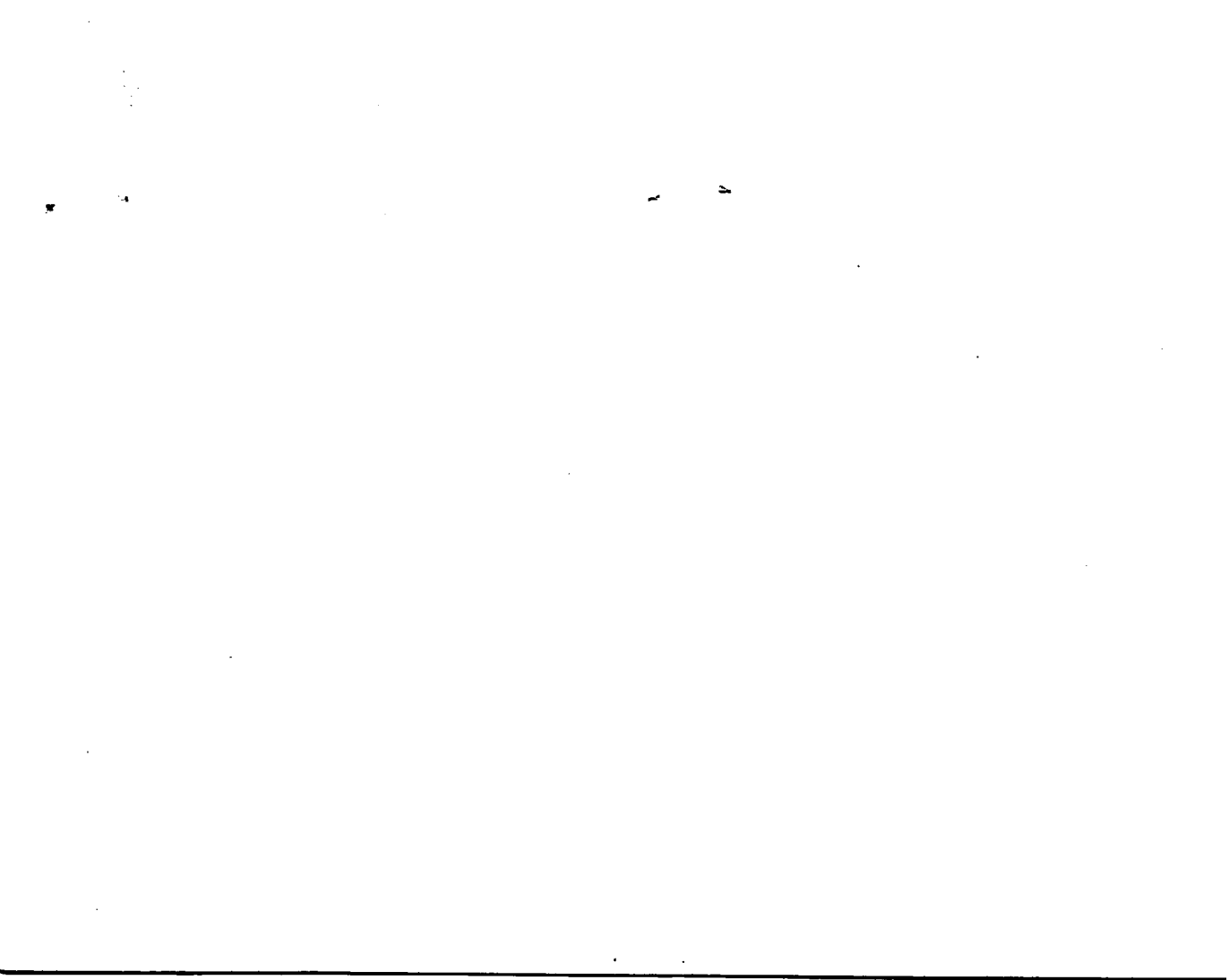
Address Sandpoint

Filed Nov 3 1923

Viola Allen

Deputy Registrar.

Registrar.



1. PLACE OF DEATH

County of BonnerCity of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born Dodd

CERTIFICATE OF DEATH

Registration District No. 78Primary Registration District No. 2155

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 43433

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct 30

(Month)

(Day)

1923
(Year)

7. AGE

stillborn

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Sandpoint, Idaho

10. NAME OF FATHER

Albert E. Dodd

11. BIRTHPLACE OF FATHER

(State or Country)

Clinton, Iowa

12. MAIDEN NAME OF MOTHER

Myrtle L. M. Chilcote

13. BIRTHPLACE OF MOTHER

(State or Country)

Flower, Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Albert Dodd(Address) Granite

15.

Filed Oct 30 1923Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 30 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 30 - 1923 19

that I last saw h..... alive on..... 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Twin birth single sack
Believe cord became
compressed,
Dead about one week.
Contributory 8 1/2 mo. gestation

(Duration) yrs. mos. ds.

(Signed) Floyd B. WendtOct 30 1923 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lakeview Cem

DATE OF BURIAL

Oct 31 1923

20. UNDERTAKER

L. G. Moon

ADDRESS

Sandpoint

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

116089

County of Boundary

City of Maples

No. 555-118-011-863

Hospital _____

RECEIVED

OCT 2 1923

Registration District No. _____

Primary Registration District No. 2156

CERTIFICATE OF BIRTH

File No. _____

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth. <u>Sept 18</u> 192 <u>3</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 7 Number of child of this mother now living, including present birth... 4

FULL NAME <u>Wm Everett</u>	FATHER	FULL MAIDEN NAME <u>Sarah Alice Holsten</u>	MOTHER
RESIDENCE <u>Maples Idaho</u>		RESIDENCE <u>Maples Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Wisconsin</u>		BIRTHPLACE <u>Minnesota</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

R. B. Bowall

Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

Bonnes Ferry Idaho

Filed

9/18/1923

Registrar.

Registrar.

DEPARTMENT OF PUBLIC HEALTH
 DISTRICT OF COLUMBIA

County of _____
 State of _____

Birth Certificate No. _____

Name of child at birth		Sex	
Date of birth		Place of birth	
Parents' names		Maiden name of mother	
Occupation of father		Occupation of mother	
Residence at birth		Residence at present	
Birthplace		Date of last visit	
Signature of physician or midwife		Signature of registrar	

Signature of physician or midwife: _____
 Signature of registrar: _____
 Date: _____

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DISTRICT OF COLUMBIA HEALTH DEPARTMENT. IT IS NOT VALID FOR OTHER PURPOSES.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU OF VITAL
STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 43449

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary) Placental Infarct

(Duration) yrs. mos. ds.

(Signed) R. B. Bowell M. D.

Sept 18 23 (Address) Bomers Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

996-111 020-294
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

County of Elmore NOV 10 1923

City of Hammett BUREAU OF VITAL STATISTICS

Registration District No. 35

File No. 116195

No. _____ St. _____

Primary Registration District No. 2021

Registered No. _____

Hospital _____
FULL NAME OF CHILD Unnamed

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u> (To be answered only in event of plural births)	and	Number in order of birth <u>3rd</u>	Legitimate? <u>yes</u>	Date of Birth <u>Oct 11</u> 19 <u>23</u> (Month) (Day) (Year)
--------------------------	---	-----	--	------------------------	--

FATHER
FULL NAME Henry J. Smith
RESIDENCE Hammett Idaho
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Idaho
OCCUPATION Carb. D.S.

MOTHER
FULL MAIDEN NAME Beatrice Burr
RESIDENCE Hammett Idaho
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at 3 A M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. W. Davis M. D.
Physician

(Physician or midwife)

Given names added from a supplemental report. _____ 19____

Address

Elmore, Idaho

Filed

Oct. 20 1923

J. W. Davis

Registrar.

Registrar.

UNITED STATES
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 DIVISION OF RECORDS AND STATISTICS
 OFFICE OF THE REGISTRAR
 WASHINGTON, D. C. 20540

STATE OF MARYLAND
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 DIVISION OF RECORDS AND STATISTICS
 OFFICE OF THE REGISTRAR

County of _____
 City of _____
 Registration District No. _____
 No. _____
 Primary Registration District No. _____
 Registered No. _____
 Hospital _____
 FULL NAME OF CHILD _____
 Sex of Child _____
 (If answered only in event of plural births)
 Rank in order of birth _____
 Date of Birth (Month, Day, Year) _____
 FULL NAME OF FATHER _____
 FULL NAME OF MOTHER _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY (Years) _____
 BIRTHPLACE _____
 OCCUPATION _____
 BIRTHPLACE _____
 OCCUPATION _____
 Number of child of this mother, including present birth _____
 Number of children of the mother now living, including present birth _____
 CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____
 on the date above stated.
 (Physician or Midwife)
 (Signature)
 Address _____
 Date _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

Form V. S. No. 5. 10M. 6-20-11.

NOV 10 1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH Elmer Schuler No. 35
County of Hammett Schuler Primary Registration District No. 2021
City of Hammett Schuler (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unarmed

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 43499

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH Oct. 11 1923
(Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day
how many _____ hrs. or
_____ yrs. _____ mos. _____ ds. _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Hammett Schuler

10. NAME OF FATHER

Henry Truini

11. BIRTHPLACE OF FATHER

(State or Country) Am.

12. MAIDEN NAME OF MOTHER

Beatrice Bumsen

13. BIRTHPLACE OF MOTHER

(State or Country) Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Truini
(Address) Hammett Schuler

15.

Filed Oct. 11 1923 J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 11 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11 1923, to Oct. 11 1923, that I last saw him alive on Still Born 11 1923, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Still Born Premature

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) Unknown

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. W. Davis M. D.
Oct. 11 1923 (Address) Hammett Schuler

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hammett Schuler Oct. 11 1923

20. UNDERTAKER ADDRESS

Henry Truini Hammett Schuler

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Premont

City of St. Anthony

No. 133-226-022-749 St.

BUREAU OF VITAL

STATISTICS

Registration District No. 99

State File No. 152

Primary Registration District No. 277

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>October 26, 1923</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth 0

FULL NAME

FATHER

FULL MAIDEN NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

(Years)

COLOR

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 20 17 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed 10/31

192 3

Registrar.

Registrar.

1. I hereby certify that I am a duly qualified and licensed physician or midwife, and that I am duly qualified and licensed to practice my profession in the State of New York.
 2. I hereby certify that I am a duly qualified and licensed physician or midwife, and that I am duly qualified and licensed to practice my profession in the State of New York.
 3. I hereby certify that I am a duly qualified and licensed physician or midwife, and that I am duly qualified and licensed to practice my profession in the State of New York.

Hospital _____
 No. _____
 Primary Registrar's District No. _____
 Local Registrar's No. _____
 State File No. _____
 CERTIFICATE OF BIRTH 113244
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

FULL NAME OF CHILD _____
 Sex of Child _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____
 (To be completed only in cases of hospital birth)

Was postnatal examination made in case? _____
 Name of child at birth _____
 Name of mother _____
 Name of father _____
 Residence _____
 Color _____
 Age at last birthday _____
 Birthplace _____
 Birth date _____
 Color _____
 Age at last birthday _____
 Birthplace _____
 Birth date _____
 Name of mother _____
 Name of father _____
 Residence _____
 Color _____
 Age at last birthday _____
 Birthplace _____
 Birth date _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.
 I hereby certify that I attended the birth of this child, and that I am duly qualified and licensed to practice my profession in the State of New York.
 Signature _____
 (Physician or midwife)
 102

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of FreemontCity of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. 99

NOV 2 1923

Primary Registration District No. 2177

BUREAU OF VITAL STATISTICS

2. FULL NAME Stillborn

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 48

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle

(Write the word.)

6. DATE OF BIRTH

October 26th, 1923
(Month) (Day) (Year)

7. AGE

XX Yrs. XX Mos. XX ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

St. Anthony Idaho.

10. NAME OF FATHER

Cecel Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Lewiston, Utah.

12. MAIDEN NAME OF MOTHER

Pearl Turney

13. BIRTHPLACE OF MOTHER

(State or Country)

St. Anthony, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cecel Allen(Address) St. Anthony, Idaho.

15.

Filed Oct. 26th, 19 23Wm. Hansen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 26, 19 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

X 19..... to Oct 26 19 23

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Prolonged labor.
Spontaneous delivery.
Stillborn
(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration)..... Yrs..... mos..... ds.

(Signed)

Thos. J. Leggett, D.
Oct 26 19 23 (Address) St. Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parker, Idaho

DATE OF BURIAL

Oct 26 19 23

20. UNDERTAKER

Wm. Hansen

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

249-227 023-522
PLACE OF BIRTH

RECEIVED
NOV 13 1923
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS

S

County of Gem
City of Emmett
No. _____ St. _____
Hospital _____ Primary Registration District No. _____ Registered No. 116256
Registration District No. 6

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>—</u> and <u>—</u> Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>10-27</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER	MOTHER
FULL NAME <u>Charles Smith</u>	FULL MAIDEN NAME <u>Lana Essigbeck</u>
RESIDENCE <u>Emmett</u>	RESIDENCE <u>Emmett</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>42</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Germany</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 9:30 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Benton O'Clark

(Physician or midwife)

Give names added from a supplemental report.

Address Emmett Ida

Filed 11/5 1923

Registrar.

Registrar.

RECEIVED

NOV 13 1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Emmett*City of *Emmett*

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *43521*

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Infant*

(Write the word.)

6. DATE OF BIRTH

Oct 27

(Month)

(Day)

1923
(Year)

7. AGE

new born

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

*Idaho*10. NAME OF
FATHER*Charles S. Smith*11. BIRTHPLACE
OF FATHER

(State or Country)

*Utah*12. MAIDEN NAME
OF MOTHER*Laura Essiback*BIRTHPLACE
OF MOTHER

(State or Country)

Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*C. S. Smith
Emmett Idaho*

15.

Filed

*10/27**1923**J. H. Kynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 27

(Month)

(Day)

1923
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct 27**1923*

to

*19*that I last saw him alive on *not at all**19*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Burton O. Clark M. D.*10/27/1923*

(Address)

Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

10/27/1923

20. UNDERTAKER

C. D. Bucknum

ADDRESS

*Emmett**Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison
 City of Peyburg
 No. 495-224-033-469 St. NOV 18 1923 Registration District No. 100 State File No. 116371
 Hospital _____ BUREAU OF VITAL STATISTICS Registration District No. 2178 Local Registrar's No. 585

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Female { Twin Triplet or other? } and { Number in order of birth } Legiti- mate? yes Date of birth 10-24 1923
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FULL NAME <u>John C. Dingley</u>	FATHER	FULL MAIDEN NAME <u>Matthe Ellen Morris</u>	MOTHER
RESIDENCE <u>Peyburg, Ida.</u>		RESIDENCE <u>Peyburg, Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Dillon, Mont.</u>		BIRTHPLACE <u>Morgan, Utah</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>house wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at 6 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
 Give names added from a supplemental report.

(Signature) Dr. J. H. England

(Physician or midwife)

Address Peyburg, Ida.Filed 1-1 1923

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

1. The first of these is the fact that the
 2. second of these is the fact that the
 3. third of these is the fact that the
 4. fourth of these is the fact that the
 5. fifth of these is the fact that the
 6. sixth of these is the fact that the
 7. seventh of these is the fact that the
 8. eighth of these is the fact that the
 9. ninth of these is the fact that the
 10. tenth of these is the fact that the

2

STATISTICS
BUREAU OF THE
CENSUS

116371 CERTIFICATE OF BIRTH

01580 9174 04512

(Certificate of no value without the name of child)

GOING TO HALLS FIRST

10-248
5449

(advised family to leave at time departure of ship)

What particular solution was used in 1962?

Number of child of this mother now living, including present child

MOTHER

JUL
 MIDAM
 3 MAY

FAITH

NAME

11235

COLON

YACHTS
TBAJ TBA

BIRTHPLACE

OCCUPATION

TRAJTA
YACHTING

ROADS

BIRTHPLACE

OCUPATION

STATE OF ATTENDING PHYSICIAN OR MIDWIFE

10-10-68

(97869812)

(S) (u) (b) (7) (C)

(Five names added from a telephone report
known other evidence of their guilt.
This is one that neither location nor
any should make it with a national
inability that the latter was involved
and there was no national involvement
national involvement)

2897b1a.

৬৯/৭৭

Report

103

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH **Wachus** NOV 1923
 County of **Wachus** Registration District No. **100**
 City of **Reynolds** Primary Registration District No. **2178**
 (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Calvin Dingley

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **43570**
 Registered No. **130**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **them** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Oct 24 1923
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many hrs. or
 min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Reynolds Idaho

10. NAME OF FATHER

John Calvin Dingley

11. BIRTHPLACE OF FATHER

(State or Country)

Willon Mont

12. MAIDEN NAME OF MOTHER

Matthie E Morris

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John C. Dingley

(Address)

R 3 - 1

15.

Filed

25

191 20

J. Dingley
 Local Registrar

16. DATE OF DEATH

Oct 24 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 24 1923** to **Oct 24 1923**, that I last saw him alive on **191**

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillbirth - probably due to long hard labor

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. H. Huthland** M. D.

10/24/1923 (Address) **Reynolds Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reynolds

10/25 191 23

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

435-131-042-415
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Twin Falls

NOV 7 1923

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

City of Buhl

No. _____ St. _____

Registration District No. 39

File No. 116522

Hospital _____

Primary Registration District No. 2087

Registered No. _____

FULL NAME OF CHILD

not named Donald Faye McNabb

(Certificate of no value without full name of child.)

Sex of
Child

male

1
Twins
or others?

{ and }

Number
in order
of birth

1st

Legiti-
mate?

yes

Date of
birth

10

31

1923

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? _____

Argyrol 2.0%

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 3

FULL
NAME

FATHER

J. D. McNabb

FULL
MAIDEN
NAME

MOTHER

Zan Davis

RESIDENCE

Buhl

RESIDENCE

Buhl

COLOR

white

AGE AT LAST
BIRTHDAY

4 1/2

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

3 7/8

(Years)

BIRTHPLACE

Ind.

BIRTHPLACE

Ind.

OCCUPATION

Water-Master

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

still born at 11:35 P. M.
(Born alive or stillborn)

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

A. J. McCuskey

(Physician or midwife)

Give names added from a supplemental report.

Address

Buhl, Ind.

Filed

OCT 31 1923

Registrar.

Registrar.

DEPARTMENT OF COMMERCE

NAME OF VESSEL		DATE		TIME	
NAME OF CAPTAIN		RANK		AGE	
NAME OF FIRST OFFICER		RANK		AGE	
NAME OF SECOND OFFICER		RANK		AGE	
NAME OF THIRD OFFICER		RANK		AGE	
NAME OF FOURTH OFFICER		RANK		AGE	
NAME OF FIFTH OFFICER		RANK		AGE	
NAME OF SIXTH OFFICER		RANK		AGE	
NAME OF SEVENTH OFFICER		RANK		AGE	
NAME OF EIGHTH OFFICER		RANK		AGE	
NAME OF NINTH OFFICER		RANK		AGE	
NAME OF TENTH OFFICER		RANK		AGE	
NAME OF ELEVENTH OFFICER		RANK		AGE	
NAME OF TWELFTH OFFICER		RANK		AGE	
NAME OF THIRTEENTH OFFICER		RANK		AGE	
NAME OF FOURTEENTH OFFICER		RANK		AGE	
NAME OF FIFTEENTH OFFICER		RANK		AGE	
NAME OF SIXTEENTH OFFICER		RANK		AGE	
NAME OF SEVENTEENTH OFFICER		RANK		AGE	
NAME OF EIGHTEENTH OFFICER		RANK		AGE	
NAME OF NINETEENTH OFFICER		RANK		AGE	
NAME OF TWENTIETH OFFICER		RANK		AGE	
NAME OF TWENTY-FIRST OFFICER		RANK		AGE	
NAME OF TWENTY-SECOND OFFICER		RANK		AGE	
NAME OF TWENTY-THIRD OFFICER		RANK		AGE	
NAME OF TWENTY-FOURTH OFFICER		RANK		AGE	
NAME OF TWENTY-FIFTH OFFICER		RANK		AGE	
NAME OF TWENTY-SIXTH OFFICER		RANK		AGE	
NAME OF TWENTY-SEVENTH OFFICER		RANK		AGE	
NAME OF TWENTY-EIGHTH OFFICER		RANK		AGE	
NAME OF TWENTY-NINTH OFFICER		RANK		AGE	
NAME OF THIRTIETH OFFICER		RANK		AGE	
NAME OF THIRTY-FIRST OFFICER		RANK		AGE	
NAME OF THIRTY-SECOND OFFICER		RANK		AGE	
NAME OF THIRTY-THIRD OFFICER		RANK		AGE	
NAME OF THIRTY-FOURTH OFFICER		RANK		AGE	
NAME OF THIRTY-FIFTH OFFICER		RANK		AGE	
NAME OF THIRTY-SIXTH OFFICER		RANK		AGE	
NAME OF THIRTY-SEVENTH OFFICER		RANK		AGE	
NAME OF THIRTY-EIGHTH OFFICER		RANK		AGE	
NAME OF THIRTY-NINTH OFFICER		RANK		AGE	
NAME OF FORTIETH OFFICER		RANK		AGE	
NAME OF FORTY-FIRST OFFICER		RANK		AGE	
NAME OF FORTY-SECOND OFFICER		RANK		AGE	
NAME OF FORTY-THIRD OFFICER		RANK		AGE	
NAME OF FORTY-FOURTH OFFICER		RANK		AGE	
NAME OF FORTY-FIFTH OFFICER		RANK		AGE	
NAME OF FORTY-SIXTH OFFICER		RANK		AGE	
NAME OF FORTY-SEVENTH OFFICER		RANK		AGE	
NAME OF FORTY-EIGHTH OFFICER		RANK		AGE	
NAME OF FORTY-NINTH OFFICER		RANK		AGE	
NAME OF FIFTIETH OFFICER		RANK		AGE	
NAME OF FIFTY-FIRST OFFICER		RANK		AGE	
NAME OF FIFTY-SECOND OFFICER		RANK		AGE	
NAME OF FIFTY-THIRD OFFICER		RANK		AGE	
NAME OF FIFTY-FOURTH OFFICER		RANK		AGE	
NAME OF FIFTY-FIFTH OFFICER		RANK		AGE	
NAME OF FIFTY-SIXTH OFFICER		RANK		AGE	
NAME OF FIFTY-SEVENTH OFFICER		RANK		AGE	
NAME OF FIFTY-EIGHTH OFFICER		RANK		AGE	
NAME OF FIFTY-NINTH OFFICER		RANK		AGE	
NAME OF SIXTIETH OFFICER		RANK		AGE	
NAME OF SIXTY-FIRST OFFICER		RANK		AGE	
NAME OF SIXTY-SECOND OFFICER		RANK		AGE	
NAME OF SIXTY-THIRD OFFICER		RANK		AGE	
NAME OF SIXTY-FOURTH OFFICER		RANK		AGE	
NAME OF SIXTY-FIFTH OFFICER		RANK		AGE	
NAME OF SIXTY-SIXTH OFFICER		RANK		AGE	
NAME OF SIXTY-SEVENTH OFFICER		RANK		AGE	
NAME OF SIXTY-EIGHTH OFFICER		RANK		AGE	
NAME OF SIXTY-NINTH OFFICER		RANK		AGE	
NAME OF SEVENTIETH OFFICER		RANK		AGE	
NAME OF SEVENTY-FIRST OFFICER		RANK		AGE	
NAME OF SEVENTY-SECOND OFFICER		RANK		AGE	
NAME OF SEVENTY-THIRD OFFICER		RANK		AGE	
NAME OF SEVENTY-FOURTH OFFICER		RANK		AGE	
NAME OF SEVENTY-FIFTH OFFICER		RANK		AGE	
NAME OF SEVENTY-SIXTH OFFICER		RANK		AGE	
NAME OF SEVENTY-SEVENTH OFFICER		RANK		AGE	
NAME OF SEVENTY-EIGHTH OFFICER		RANK		AGE	
NAME OF SEVENTY-NINTH OFFICER		RANK		AGE	
NAME OF EIGHTIETH OFFICER		RANK		AGE	
NAME OF EIGHTY-FIRST OFFICER		RANK		AGE	
NAME OF EIGHTY-SECOND OFFICER		RANK		AGE	
NAME OF EIGHTY-THIRD OFFICER		RANK		AGE	
NAME OF EIGHTY-FOURTH OFFICER		RANK		AGE	
NAME OF EIGHTY-FIFTH OFFICER		RANK		AGE	
NAME OF EIGHTY					

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Luna
City of BunburyRECEIVED
DEC 31
BUREAU
STATERegistration District No. 39
Primary Registration District No. 7087File No. 44270
Registered No. 44270

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William McHabb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Oct 31 1923
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burl Idaho

10. NAME OF FATHER

J. M. McHabb

11. BIRTHPLACE OF FATHER

(State or Country) Indiana

12. MAIDEN NAME OF MOTHER

Jan Davis

13. BIRTHPLACE OF MOTHER

(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) J. M. McHabb

15.

Filed Nov. 1 1923J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 31 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...
that I last saw him at home
and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH* was as follows:

I was born premature
birth - Placenta Previa
the first born of twins.
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

A. J. Hurlburt M. D.11/19/23 (Address) Burl Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burl 11-1 1923

20. UNDERTAKER

ADDRESS

J. H. Johnson Burl Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

285-345-292
PLACE OF BIRTH

RECEIVED
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
NOV 3 1923

County of Twin Falls
City of Twin Falls
No. 39 Registration District No. 39 State File No. 116525

Hospital Co General Primary Registration District No. 1085 Local Registrar's No. 1085

FULL NAME OF CHILD Nellie Maria Byers
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? — and { Number in order of birth — Legitimate? Yes Date of birth Sept 6 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Ernest Dwight Byers</u>	FULL MAIDEN NAME	<u>Greer Bishop</u>
RESIDENCE	<u>Pilot, Berger.</u>	RESIDENCE	<u>Berger</u>
COLOR	<u>white</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>20</u> (Years)
BIRTHPLACE	<u>Kansas</u>	BIRTHPLACE	<u>Colorado</u>
OCCUPATION	<u>Engineer</u>	OCCUPATION	<u>housewife</u>

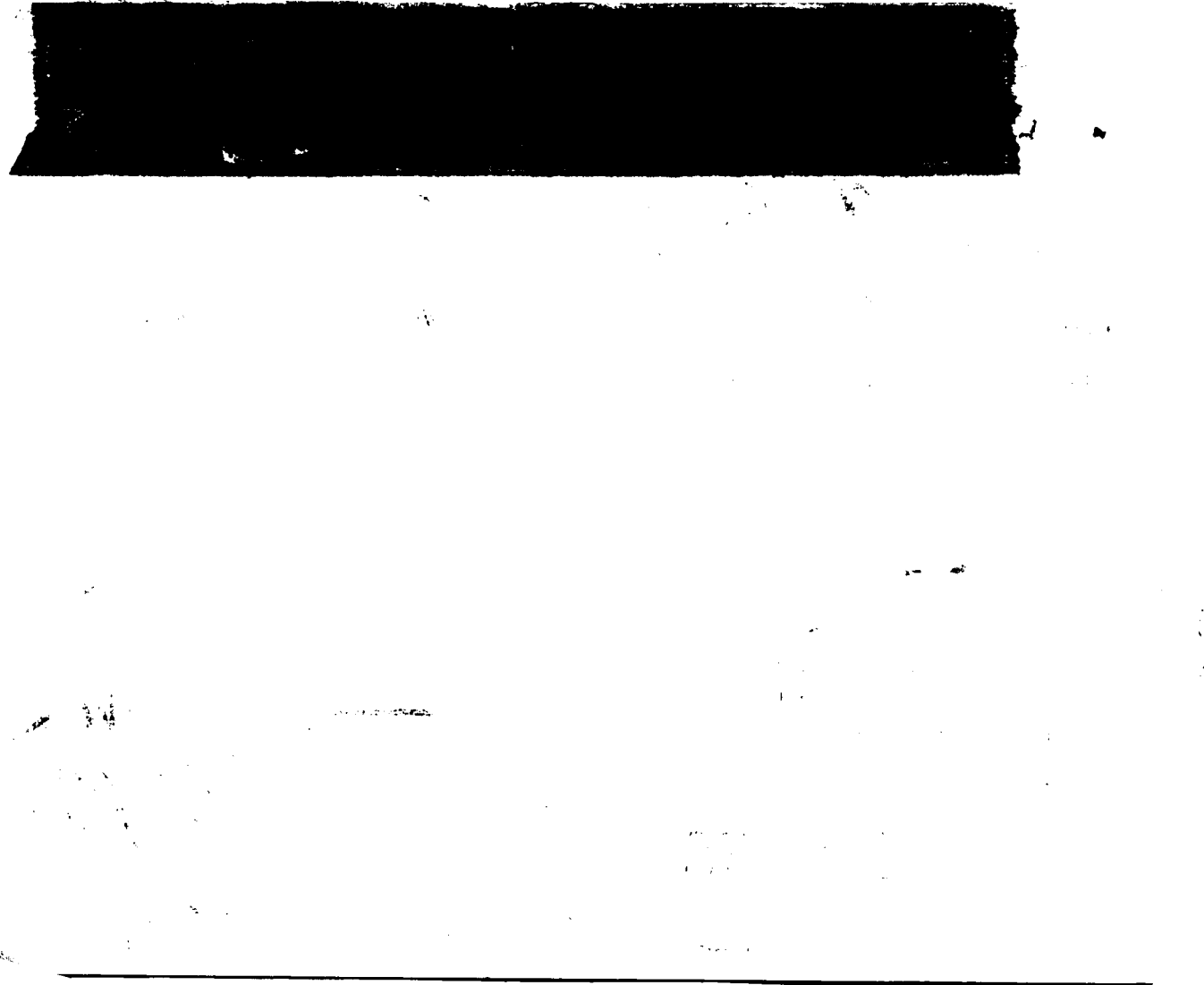
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn { Deceased } at 3 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. —, 192—

Address —
Filed 71015.1 1923 John N. Coughlin
Registrar. Registrar.



1. PLACE OF DEATH

County of *Twini Falls*City of *"*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mellie Marie Byers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept 6 1923
(Month) (Day) (Year)

7. AGE

*Yrs. — Mos. — ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ernest Dwight Byers

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Preda Bishop

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Preda Byers(Address) *Berger, Idaho*

15.

Filed *Oct. 1 1923**John F. Coughlin*
Local Registrar

RECEIVED

1923
BUREAU OF VITAL
STATISTICS
STATS.

CERTIFICATE OF DEATH

Registration District No. *37.*County Registration District No. *2085.*City of *Berger, Ida.*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *43351*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Unknown
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Prenatal - Cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank A. Dwight
Felix J. J.

..... 19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Siler - Idaho

DATE OF BURIAL

9-7-1923

20. UNDERTAKER

J. J. Grossman

ADDRESS

Twini Falls
Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

699-112-042-695
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Twin Falls NOV 3 1923

City of Twin Falls BUREAU OF VITAL STATISTICS

No. R.R.T. St.

Registration District No.

37.
2085.

File S 116534

Hospital _____ Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD

Tauf H. Green

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <u>Green</u> { and { Number in order of birth <u>1</u> Triplet or other? (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>9</u> <u>12</u> <u>1923</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

What bactericidal solution was used in eyes? 170

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Jacob H. Greening
RESIDENCE Twin Falls Ida.
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Minnesota
OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Katharina Wiebe
RESIDENCE Twin Falls Ida.
COLOR White AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Minnesota
OCCUPATION Housekeeping

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born dead at 8:00 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

W. G. Tibb

Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

Twin Falls Ida.

Filed Nov 1 1923

John F. Connelley
Registrar.

Registrar.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 148
 County of Quinn Teller **BURBANK** Registration District No. 148
 City of Quinn Teller No. 148 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Baby) Paul Friesen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 11111Registered No. 11111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept 18 1923
 (Month) (Day) (Year)

7. AGE

Steelborn
Yrs. 1 Mos. 10 ds. 10

IF LESS than 1 day
 how many 1 hrs.
 or 10 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓
 (b) General nature of industry, business or establishment in which employed (or employer) ✓

9. BIRTHPLACE

(State or Country) Quinn Teller Ida.

10. NAME OF FATHER

Jacob Friesen

11. BIRTHPLACE OF FATHER

(State or Country) Minnesota

12. MAIDEN NAME OF MOTHER

Katharina Wiebe

13. BIRTHPLACE OF MOTHER

(State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Friesen(Address) Quinn Teller Ida.

15.

Filed Sept 10 1924

C. D. Piper M.D.
 Local Registrar

16. DATE OF DEATH

9 12 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 12 1923 to Sept 12 1923
 that I last saw Steelborn 1923
 and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Strangulation from
hanging from neck with
cord around neck

(Duration) 1 Yrs. 10 mos. 10 ds.

Contributory (Secondary)

(Duration) 1 yrs. 10 mos. 10 ds.(Signed) W. G. T. J.

M. D.

9/12/1923 (Address) Quinn Teller Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 10 mos. 10 days. In the State 1 yrs. 10 mos. 10 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Private cemetery near Quinn Teller

DATE OF BURIAL

9/12/1923

20. UNDERTAKER

J. G. T. J.

ADDRESS

Quinn Teller Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

582-113-001-154
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-3-37

S

County of... Ada

DEC 4 1923

City of... Boise

BUREAU OF VITAL STATISTICS

State District No.

File No. 116574

No. St.

Primary Registration District No. 1004

Registered No. 347

Hospital St. Luke's

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> (To be answered only in event of plural births)	and { Number in order of birth <u> </u> }	Legitimate? <u>Yes</u>	Date of Birth <u>Nov 13</u> 1923 (Month) (Day) (Year)
--------------------------	---	--	------------------------	--

FATHER		MOTHER	
FULL NAME <u>Carl A. Nyberg</u>	FULL MAIDEN NAME <u>Clea Anderson</u>	FULL NAME <u>Carl A. Nyberg</u>	FULL MAIDEN NAME <u>Clea Anderson</u>
RESIDENCE <u>206 Myrhee Blvd. Boise</u>	RESIDENCE <u>206 Myrhee Blvd. Boise</u>	RESIDENCE <u>206 Myrhee Blvd. Boise</u>	RESIDENCE <u>206 Myrhee Blvd. Boise</u>
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Sweden</u>	BIRTHPLACE <u>Minnesota</u>	BIRTHPLACE <u>Sweden</u>	BIRTHPLACE <u>Minnesota</u>
OCCUPATION <u>Machinist</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Machinist</u>	OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth... 2 ... Number of children of this mother now living, including present birth... 2 ...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 9:00 p.m. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. Carl Hill, M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address Boise, Idaho

Filed Nov 20 1923

Registrar

Registrar

SECRET

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov 14

1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him — alive on — 19

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

(Duration) — Yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) — M. D.

11/14, 1923, (Address) —

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

366-109-601-319
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada DEC 4 1923
City of Boise BUREAU OF VITAL
No. 311 E State St. Registration District No. 7 File No. 116592
Hospital _____ Primary Registration District No. 1004 Registered No. 357
FULL NAME OF CHILD Coonrod
(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>L</u>	Date of birth <u>Nov 9</u> 192 <u>3</u> (Month) (Day) (Year)
-----------------------	------------------------------	--	----------------------	---

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? Credé Solution

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FULL NAME <u>Arthur F. Coonrod</u>	FATHER	FULL MAIDEN NAME <u>Myrtle Carter</u>	MOTHER
RESIDENCE <u>Boise Idaho</u>		RESIDENCE <u>Boise Idaho</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Kansas</u>		BIRTHPLACE <u>Colo</u>	
OCCUPATION <u>Timber Cruiser</u>		OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 6 a.m.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Joseph V. Smith
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Boise
Filed Nov 20 1923 R. N. Pratt
Registrar.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
DEC 4 1923BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. 1311 E State St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7th 1923, to Nov 9th 1923 that I last saw him alive on Nov 7th 1923, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

11/9 1923.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

663-126-001-163
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Ada RECEIVED
City of Boise DEC 4 1923
No. 2 Registration/District No. 2 File No. 116613
Hospital St. Luke's Primary Registration District No. 1004 Registered No. 383
FULL NAME OF CHILD Joseph Wolfgang
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twins or other? <u>—</u> and <u>—</u> Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct-26</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? —

Number of child of this mother, including present birth... 10 Number of child of this mother now living, including present birth... 0

FATHER		MOTHER	
FULL NAME	<u>John Wolfgang</u>	FULL MAIDEN NAME	<u>Lelia Jane Jolley</u>
RESIDENCE	<u>609 So. 13th St.</u>	RESIDENCE	<u>609 So. 13th St.</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>30</u> (Years)	AGE AT LAST BIRTHDAY	<u>28</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Auto Mechanic</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn, at 8:45 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. M. Taylor
M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Boise Idaho

Filed Nov 16 1923

Registrar.

Registrar.

STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH

Date of Birth: <u>1914</u> Place of Birth: <u>NEW YORK</u>		Date of Death: <u>1914</u> Place of Death: <u>NEW YORK</u>	
Name of Child: <u>JOHN</u> Sex: <u>MALE</u>		Name of Child: <u>JOHN</u> Sex: <u>MALE</u>	
Name of Mother: <u>MARY</u> Name of Father: <u>JOHN</u>		Name of Mother: <u>MARY</u> Name of Father: <u>JOHN</u>	
Residence: <u>NEW YORK</u> Color: <u>WHITE</u>		Residence: <u>NEW YORK</u> Color: <u>WHITE</u>	
Birthplace: <u>NEW YORK</u> Occupation: <u>LABORER</u>		Birthplace: <u>NEW YORK</u> Occupation: <u>LABORER</u>	

I, JOHN, Registrar of Births and Deaths, do hereby certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Bureau of Vital Statistics of the State of New York.

Given under my hand and the seal of the Bureau of Vital Statistics, at the City of New York, this 1st day of January, 1914.

Registrar of Births and Deaths

This is to certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Bureau of Vital Statistics of the State of New York.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **43375**Registered No. **233**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Adm. NOV 13 1923**
 County of **Ada** Registration District No. **1**
 City of **Bain** Primary Registration District No. **1**
St. Luke's Hospital (St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Joseph. Halfkirk**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
 (Write the word.)
 6. DATE OF BIRTH **10/26/23**
Still Born
 (Month) (Day) (Year)
 7. AGE **Still Born**
 Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Bain, Idaho

10. NAME OF FATHER

John -

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lelia Jolley

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D. McBratney
Bain, Idaho

15.

Filed **Oct. 29 1923****R. N. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 26 - 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct. 26th 1923**, to **Oct 26th 1923**
 that I last saw him **alive on Still born**
 and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Cause of death unknown - delivered at 34 weeks, but had evidently been dead some day or possibly several days.
 (Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.
Mother had toxemia of pregnancy
 (Signed) **J. J. Taylor** M. D.
10/27/23 (Address) **Bain, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Morris Hill Cemetery** DATE OF BURIAL **10/27 1923**

20. UNDERTAKER

ADDRESS

D. McBratney **Bain, Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

439-226,001-653
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada RECEIVED
City of Boise DEC 4 1923
No. 548 Wash BUREAU OF VITAL
1122 Grand St. STATISTICS
Hospital _____ Registration District No. 1004 File No. 116615
Primary Registration District No. 1004 Registered No. 392
FULL NAME OF CHILD Larnet McRoberts
(Certificate of no value without full name of child.)

Sex of Child <u>F</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and } Number in order of birth _____	Legitimate? <u>L</u>	Date of birth <u>Oct 26</u> 192 <u>3</u> (Month) (Day) (Year)
-----------------------	---	--------------------------------------	----------------------	--

What bacterioidal solution was used in eyes? None

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FULL NAME <u>Tom McRoberts</u>	FULL MAIDEN NAME <u>B. Welch</u>
RESIDENCE <u>Boise</u>	RESIDENCE <u>Boise</u>
COLOR <u>W</u>	COLOR <u>W</u>
AGE AT LAST BIRTHDAY <u>47</u> (Years)	AGE AT LAST BIRTHDAY <u>47</u> (Years)
BIRTHPLACE <u>Mo.</u>	BIRTHPLACE <u>Mo.</u>
OCCUPATION <u>Labourer</u>	OCCUPATION <u>H. W.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at Boise on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. B. Welch
(Physician or midwife)

Give names added from a supplemental report.

Address Boise
Filed Nov 10 1923 Registrar.

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Form and Registration Number

10-10-40 31

101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554
-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

1. The first of these is the fact that the majority of the population of the United States is of European descent. This is a fact which has been recognized by the government and the people of the United States for many years. It is a fact which has been recognized by the government and the people of the United States for many years.

NAME	WATSON
REL	FATHER
RES	1000 1/2 N. 10TH ST. S. MINNAPOLIS, MINN.
RESIDENCE	1000 1/2 N. 10TH ST. S. MINNAPOLIS, MINN.
NAME	MOTHER
REL	MOTHER
RES	1000 1/2 N. 10TH ST. S. MINNAPOLIS, MINN.
RESIDENCE	1000 1/2 N. 10TH ST. S. MINNAPOLIS, MINN.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
1	2	3	4	5	6	7	8	9	10	11	12	13</																																																																																							

DATE	10/10/54
TIME	10:10
LOCATION	10:10
PERSON	10:10
REMARKS	10:10

STATE OF ATTENDING PHYSICIAN OF MIDWIFE

NEW ORLEANS, La. (AP) — A major fire destroyed a large portion of the city's historic French Quarter district Sunday night, leaving a large area of the city's historic district in flames.

(b) (7) (D)

100-443887-100

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho DEC 12 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

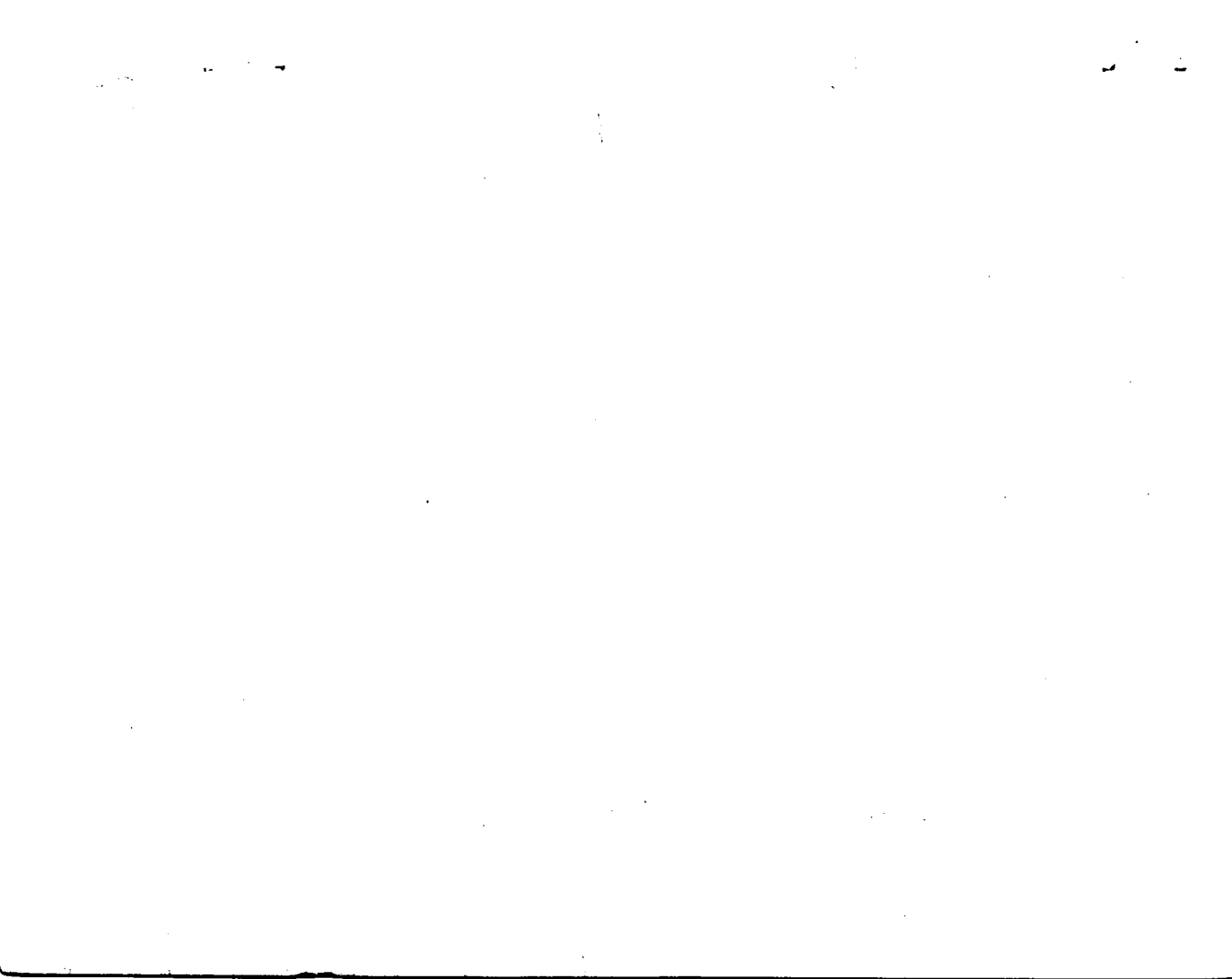
Place of Birth	CITY	<u>Boise</u>	FILE NO.	<u>116615</u>
	ST.	<u>Grandave</u>	DATE OF BIRTH	<u>OCT 26 - 1923</u>
	COUNTY	<u>Ada</u>	SEX OF CHILD	<u>Female</u>
	FATHER	<u>J. M. M^r Roberts</u>	MOTHER	<u>Bedie Welch.</u> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Garnet M^r Roberts

J. M. M^r Roberts

RECEIVED
DEC 12 1923



1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 23

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

STATISTICAL DISTRICT No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. u. u. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

10/27/23

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

168-219001-143
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

116617

County of Ada
City of Eagle
No. _____ St. _____
Hospital _____ Primary Registration District No. 9510 File No. 54
Registered No. 54
FULL NAME OF CHILD Mary Johnson

RECEIVED
DEC 4 1923
BUREAU OF VITAL
STATISTICS

Sex of Child M Twin Triplet or other? — and — Number in order of birth — Legitimate? yes Date of birth 11 19 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 2% Saline

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER FULL NAME <u>Walter A. Johnson</u>		MOTHER FULL MAIDEN NAME <u>Matilda Johnson</u>	
RESIDENCE <u>Eagle Idaho R. D.</u>		RESIDENCE <u>Eagle R. D.</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>France</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Rev.</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born dead 20 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

_____, 19____

Registrar.

(Signature) Malcolm Callaway
Physician
(Physician or midwife)
Address Boise Idaho
Filed 11/22 1923 Orville Johnson
Eagle Idaho Registrar.

2

Mother's maiden name added from certificate #145829.

Dup. of 1923-145829

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

43651

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ada*
City of *Eagle*

Registration District No. *8*

Primary Registration District No. *7008*

(No. *5 Miles N.W. Eagle* St.)

File No.

Registered No. *(64)*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Baby Mary Johnson*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH *Nov 19 1923*
(Month) (Day) (Year)

7. AGE *still born*
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Eagle, Idaho.*
(State or Country)

10. NAME OF FATHER *Walter H Johnson*

11. BIRTHPLACE OF FATHER *Iowa*
(State or Country)

12. MAIDEN NAME OF MOTHER *Matilda C. Jullion*

13. BIRTHPLACE OF MOTHER *France*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Walter H Johnson*
(Address) *Eagle, Ida.*

15. Filed *Nov 20 1923* *R. S. Burt*
Local Registrar

16. DATE OF DEATH

Nov 19 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 1923 that I last saw him alive on 19 and that death occurred on the date stated above, at 3 A. M. The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. Allen Calkins* M. D.

1923 (Address) *824 Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Ada County*

19. PLACE OF BURIAL OR REMOVAL *St Johns Cemetery* DATE OF BURIAL *11/20/1923*

20. UNDERTAKER *Schreiber & Widupada* ADDRESS *(Boise)*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

231-045-240
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Benedict **RECEIVED**
City of Desmet **DEC 6 1923**
CERTIFICATE OF BIRTH 116714

No. 31 St. STATISTICS File No. 2
Hospital Primary Registration District No. Registered No. 661

FULL NAME OF CHILD Unnamed Stanger
(Certificate of no value without full name of child.)

Sex of Child <u>7.</u>	Twin Triplet or other? <u> </u> (To be answered only in event of plural births)	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Nov. 11. 1923.</u> (Month) (Day) (Year)
------------------------	---	--	------------------------	---

What bacterioidal solution was used in eyes?

Number of child of this mother, including present birth Number of children of this mother now living, including present birth

FATHER		MOTHER	
FULL NAME <u>Daniel Stanger</u>	FULL MAIDEN NAME <u>A. Cowrie</u>	FULL NAME <u>A. Cowrie</u>	FULL MAIDEN NAME <u> </u>
RESIDENCE <u>Tensed. Ida.</u>	RESIDENCE <u>Tensed. Ida.</u>	RESIDENCE <u>Tensed. Ida.</u>	RESIDENCE <u> </u>
COLOR <u>Indian</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Oregon</u>	BIRTHPLACE <u>Oregon</u>	BIRTHPLACE <u> </u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u> </u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was St. Albans at 5 A. M.
on the date above stated. (Born alive or stillborn)

{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature) Daniel Stanger
(Physician or midwife)

Give names added from a supplemental report.
 , 192

Registrar.

Address Tensed. Ida.
Filed Nov. 11. 1923
G. E. Pihau
Registrar.

CERTIFICATE OF BIRTH 115714

County of _____
City of _____
No. _____
Registration District No. _____
Primary Registration District No. _____
Registered No. _____
FULL NAME OF CHILD _____
(Indicate if no name within full name of child)

Sex of Child _____	Age of Child _____	Weight _____	Length _____	Birth _____
Number of children of this mother now living, including present birth _____				
FATHER		MOTHER		
NAME _____	NAME _____	NAME _____	NAME _____	NAME _____
RESIDENCE _____	RESIDENCE _____	RESIDENCE _____	RESIDENCE _____	RESIDENCE _____
BIRTHPLACE _____	BIRTHPLACE _____	BIRTHPLACE _____	BIRTHPLACE _____	BIRTHPLACE _____
COLOR _____	COLOR _____	COLOR _____	COLOR _____	COLOR _____
AGE AT LAST BIRTHDAY _____ (Years)	AGE AT LAST BIRTHDAY _____ (Years)	AGE AT LAST BIRTHDAY _____ (Years)	AGE AT LAST BIRTHDAY _____ (Years)	AGE AT LAST BIRTHDAY _____ (Years)
OCCUPATION _____	OCCUPATION _____	OCCUPATION _____	OCCUPATION _____	OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was _____
(From birth to 24 hours)
_____ (Signature)
_____ (Address)
_____ (City)
_____ (State)
_____ (Date)

ORIGINAL FILED IN 115714
CERTIFICATE OF BIRTH
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF IOWA
JAN 10 1924

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BennettCity of Dennet

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed Hanger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F. Indian

(Write the word.)

6. DATE OF BIRTH

Nov. 11 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

Yrs. Mos. da.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Daniel Hanger

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

A. Course

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel Hanger

(Address)

Dennet, Idaho

15.

Filed Nov. 11 1923G. L. Pihlan
Local RegistrarState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 2 43681Registered No. 26

If death occurred in a hospital, institution or nursing home, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 11 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn - Cause unknown

(Duration) Yrs. mos. da.

Contributory
(Secondary)

(Duration) yrs. mos. da.

(Signed) M. E.19 (Address)

*State the Disease Causing Death; or in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Dennet

DATE OF BURIAL

Nov. 11 1923

20. UNDERTAKER

J. F. Faleon

ADDRESS

Dennet, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill;* (a) *Salesman, (b) Grocery;* (a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

71-128-000-295
PLACE OF BIRTH
County of Bingham RECD
City of Blackfoot DEC 6
No. E. Pacific BUREAU
Registration District No. 131 State File No. 116751
Hospital _____ Primary Registration District No. 007 Local Registrar's No. 433
FULL NAME OF CHILD Gavoille

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and Number in order of birth 5 Legitimate? yes Date of birth Nov 28 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? argyrol

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME C. J. Gavoille
RESIDENCE Blackfoot
COLOR White AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Colorado
OCCUPATION Carpenter

MOTHER
FULL MAIDEN NAME Mable Bingham
RESIDENCE Blackfoot
COLOR White AGE AT LAST BIRTHDAY 33
(Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7 9 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. W. Beck

(Physician or midwife)

Address Blackfoot Idaho

Filed Dec 3 1923 Mr. C. C. C. C. C.

Registrar.

Registrar.

[illegible]

STATE OF ALABAMA

100-443886-100

BIRTHPLACE

70109

Figure 1. The effect of the concentration of the inhibitor on the rate of polymerization of α -methylstyrene in the presence of SnCl_4 at 25°C . The concentration of α -methylstyrene was 1.0 mol/L, and the concentration of SnCl_4 was 0.01 mol/L. The concentration of the inhibitor was 0.001 mol/L (○), 0.002 mol/L (□), 0.005 mol/L (△), 0.01 mol/L (◇), 0.02 mol/L (×), 0.05 mol/L (●), 0.1 mol/L (○), 0.2 mol/L (◇), 0.5 mol/L (×), 1.0 mol/L (●).

RECEIVED

NAME _____

Number of ability to read and write in English

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the situation.

Letter of Appreciation, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 26

(The enclosed only is even of
or other

[illegible]

1111597

LIST OF CHIEFS OF CHIEFS

10-10-57



CONFIDENTIAL

SECRET

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho DEC 12 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth (CITY Blackfoot FILE NO. 116751
ST. East Idaho St. DATE OF BIRTH Nov. 21
COUNTY Bingham SEX OF CHILD Male
FATHER C. E. Garville MOTHER Mabel S. Simpson
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

The little child was of premature birth
and only 6 months. I don't see the necessity of
registration. You see it had no name.

Signature of Father or Mother.

20 20 20 20 20

CE
8
17
71

Yoda, to the end of the line

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form No. 1-19

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Minor Dis.

Primary Registration 1

F DEATH

1/

No. 21941007

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43701

Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME No Name Gaville

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

Nov 28 1923
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Constant J. Gaville

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

Mable Bingham

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. J. Gaville

(Address)

Blackfoot, Idaho

15.

Filed Nov 28 1923

McClintock

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn

Nov 28 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 29 1923 to Nov 28 1923

that I last saw h. alive on Stillborn 19

and that death occurred on the date stated above, at. M.

The CAUSE OF DEATH* was as follows:

Stillborn at 5th
month cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck M. D.

11/28/23 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sub - at Home

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each, and the number of each, in order of birth stated.

113-125006-753
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham DEC 6 1923
City of Blackfoot BUREAU OF VITAL CERTIFICATE OF BIRTH 116760

No. _____ St. _____ Registration District No. 121 File No. _____

Hospital _____ Primary Registration District No. 2194 Registered No. 442

FULL NAME OF CHILD son named Jackson
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth. <u>11</u> <u>25</u> 192 <u>3</u> (Month) (Day) (Year)
-----------------------------	---	-----	--------------------------------	--------------------------------	--

What bactericidal solution was used in eyes? X

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Chas B Jackson</u>	<u>Blackfoot Ida</u>	<u>Merle V Selers</u>	<u>Blackfoot Ida</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Mo</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 7:30 A.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

_____, 19____

_____, 19____

Registrar.

(Signature) J. C. Humphreys
(Physician or midwife)

Address Blackfoot Ida

Filed Dec. 4 1923 Mrs. Wallace C. Patine
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF BIRTH

Registration District No. _____
 Registered No. _____
 Primary Registration District No. _____
 Name of Child _____

Sex of Child _____
 Date of Birth _____
 Place of Birth _____
 (If born in Idaho, give date and place of birth)

Number of child of this mother now living _____
 Name of mother _____
 Maiden name _____
 Residence _____

Color _____
 Birthplace _____
 Age at last birthday _____
 Occupation _____

Color _____
 Birthplace _____
 Age at last birthday _____
 Occupation _____

Color _____
 Birthplace _____
 Age at last birthday _____
 Occupation _____

Color _____
 Birthplace _____
 Age at last birthday _____
 Occupation _____

Color _____
 Birthplace _____
 Age at last birthday _____
 Occupation _____

Color _____
 Birthplace _____
 Age at last birthday _____
 Occupation _____

Color _____
 Birthplace _____
 Age at last birthday _____
 Occupation _____

Form T.S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bingham*City of *Panguitch*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE

DEATH

Registration District No. *21*Primary Registration District No. *2194*

St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *43702*Registered No. *139*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Nov 25 1923
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Panguitch Idaho

10. NAME OF FATHER

Chas. B. Jackson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mervie V. Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas B Jackson(Address) *Panguitch Idaho*

15.

Filed

Nov 26 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 25 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11 - 25 1923 to *19*that I last saw him alive on *19*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH was as follows:

Still Born
cause unknown
in mother
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. O. Humphreys M.D.
11-26-23 (Address) *Blackfoot Id*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas - Riverside *Nov 26 1923*

20. UNDERTAKER

ADDRESS

Chas B Jackson

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

355-130-008-355
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bosse
City of Pinehurst

RECEIVED
NOV 25 1923

CERTIFICATE OF BIRTH

No. 12 District No. 12 State File No. 116773

Hospital Primary Registration District No. 12 Local Registrar's No.

FULL NAME OF CHILD Leonard
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin, Triplet or other? <u> </u>	and Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Sept 30</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	---	--	------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>1</u>	
FULL NAME <u>John Leonard</u>	FATHER	FULL MAIDEN NAME <u>Late Leonard</u>	MOTHER
RESIDENCE <u>Pinehurst</u>		RESIDENCE <u>Pinehurst</u>	
COLOR <u> </u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u> </u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u> </u>		BIRTHPLACE <u> </u>	
OCCUPATION <u>Logger</u>		OCCUPATION <u>House Wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at Still born on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address Marie K. K. K.

Filed Nov 10 1923 Mrs E. K. K.

192

Registrar.

Registrar.

REF ID: A60167

Primary Registration District No. _____

CONFIDENTIAL - NO FORN DISSEM

TO: Special Agent	FROM: Special Agent	DATE: 10/10/67	TIME: 10:00 AM	LOCATION: New York, NY
(Name)	(Name)	(Name)	(Name)	(Name)

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the situation.

NAME	RELATIONSHIP	DATE OF BIRTH	DATE OF DEATH	DATE OF BURIAL	DATE OF CREMATION	DATE OF INTERMENT	DATE OF REINTERMENT	DATE OF REINTERMENT	DATE OF REINTERMENT
FATHER	RESIDENCE								
FULL NAME	RESIDENCE								
DATE OF BIRTH	DATE OF DEATH								
DATE OF BURIAL	DATE OF CREMATION								
DATE OF INTERMENT	DATE OF REINTERMENT								
DATE OF REINTERMENT	DATE OF REINTERMENT								

COLON COLON

DATE OF BIRTH	1925
PLACE OF BIRTH	INDONESIA
EDUCATION	INDONESIA
RELIGION	INDONESIA
PROFESSION	INDONESIA
DATE OF DEATH	1975
PLACE OF DEATH	INDONESIA
EDUCATION	INDONESIA
RELIGION	INDONESIA
PROFESSION	INDONESIA

DATE: CASE OF ATTENDING PHYSICIAN OR NURSE.

...to [redacted] saw new kind and it was I had [redacted]

(S) [REDACTED] (S)

[REDACTED]

(S) [REDACTED] (S)

SECRET

100-443887-100

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Clark Fork

No. St.

Hospital.....

FULL NAME OF CHILD.....

RECEIVED
DEC 10 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

116789

Registration District No. 78 State File No.

Primary Registration District No. 2155 Local Registrar's No.

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>♂</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u>3</u>	Legitimate? <u>yes</u>	Date of birth <u>Nov 12</u> , 192 <u>3</u> (Month) (Day) (Year)
-----------------------	----------------------------------	---	------------------------	--

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Oliver McElroy
RESIDENCE Clark Fork
COLOR W AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Penn
OCCUPATION Rancher

MOTHER
FULL MAIDEN NAME Jane Rose
RESIDENCE Clark Fork
COLOR W AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Ind
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Clark Fork on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Viola Allen

(Physician or midwife)

Address.....

Filed Dec 4 1923

Viola Allen
Deputy Registrar

Registrar.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the State of New York, at Albany, this 10th day of June, 1908.

STATE OF NEW YORK

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

116788

No. 116788 Date of Birth June 10, 1908
 Hospital St. Vincent's Physician Dr. J. J. McLaughlin
 Registrar John J. McLaughlin License No. 116788

FULL NAME OF CHILD John J. McLaughlin
 Certificate of no value without full name of child
 Sex Male Age 1 at Birth 1
 Date of Birth June 10, 1908
 Place of Birth New York City

Number of child of this mother, including present birth 1
 Number of child of this father, including present birth 1
 Name of child of this mother, including present birth John J. McLaughlin
 Name of child of this father, including present birth John J. McLaughlin

FATHER John J. McLaughlin
 MOTHER John J. McLaughlin
 COLOR White AGE AT LAST BIRTHDAY 1
 BIRTHPLACE New York City
 OCCUPATION None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was born on the date above stated.
 *If there were no attending physician or midwife, then the father and mother should make a statement that the child is not a stillborn child, and that the father and mother have no other evidence of the child's birth.
 Address John J. McLaughlin
 Registered John J. McLaughlin

1. PLACE OF DEATH

County of BonanzaCity of Clark Fork

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No. 78Registration District No. 2155

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 4344

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Nov 12 1923
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ida

10. NAME OF FATHER

Oliver M. Chung

11. BIRTHPLACE OF FATHER

(State or Country) Ida

12. MAIDEN NAME OF MOTHER

Jane Rose

13. BIRTHPLACE OF MOTHER

(State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

from birth report

(Address)

15.

Filed

Dec 4 1923Viola Allen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 12 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 12 1923 to 19that I last saw him alive on Nov 12 1923and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH was as follows:

Still Born
Approximately 7 mos.
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

For (Signed) P. B. Decker M. D.13 1923 (Address) Clark Fork

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clark Fork, Ida Nov 12 1923

20. UNDERTAKER

ADDRESS

father Clark Fork, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

316-116.017-995
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Campbell **RECEIVED** DEC 6 1923 • **CERTIFICATE OF BIRTH** **S116863**
 City of Nampa Registration District No. 7 File No. _____
 No. _____ St. _____
 Primary Registration District No. 2006 Registered No. _____
 Hospital _____
 FULL NAME OF CHILD unnamed.

Sex of Child <u>M</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	(Number in order of birth)	Legitimate? <u>yes</u>	Date of Birth <u>11-16</u> 19 <u>23</u> (Month) (Day) (Year)
FULL NAME <u>Linnel Dale Lawrence</u>	FATHER		FULL MAIDEN NAME <u>Elsie Lucinda</u>		MOTHER
RESIDENCE <u>Nampa</u>	RESIDENCE		RESIDENCE <u>Nampa</u>		RESIDENCE <u>Lueritia Island</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)		COLOR <u>White</u>		AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Iowa</u>	BIRTHPLACE		BIRTHPLACE <u>Kansas</u>		BIRTHPLACE
OCCUPATION <u>Laborer</u>	OCCUPATION		OCCUPATION <u>Housewife</u>		OCCUPATION

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 6:37 PM M.
 on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. R. Meredith
Nampa
 (Physician or midwife)

Given names added from a supplemental report. _____ 19____

Address

Filed

DEC 4 1923 Frank Dodds
 Registrar.

Registrar.

[illegible]

to y the

Registration District No.

File No.

Isigee H

NAME OF CHILD

Conf.

3044

RESIDENCE

COPIES

BE AT LAST
YACHTING

ВРАЧЕНТЪ

HCIT 44200

to be blind to the situation.

DATE OF ATTENDING

(b) (7)(D), (b) (7)(F)

...the latter ...
...the other ...

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2056

(No. _____) (St.)

File No. 1341

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Premature) Lawrence

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

11 16 1923
(Month) (Day) (Year)

7. AGE

Premature
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Canyon Co

10. NAME OF FATHER

Linnel Lawrence

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Elis Lucrrecia Lawrence

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.R. Meredith

(Address) Nampa

15.

Filed Dec 4 1923 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 16 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at delivery 1923

that I last saw him alive on 1923

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature Death
Inhalation following
dissection yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C.R. Meredith D.O. M. D.

11/16 1923 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Removed by 1923

20. UNDERTAKER ADDRESS

C.R. Meredith D.O. Nampa

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

789-211-01K-814
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon RECEIVED
City of Nampa DEC 6 1923
No. _____ St. _____ Registration District No. 7 File No. 116871
Hospital _____ Primary Registration District No. 1006 Registered No. _____
FULL NAME OF CHILD Stillborn
(Certificate of no value without full name of child.)

Sex of Child <u>girl</u>	Twins or other? <u>no</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Nov 17</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	---------------------------	-----------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth 0

FATHER	MOTHER
FULL NAME <u>Charles Milton Philpott</u>	FULL MAIDEN NAME <u>Violet D. Hauck</u>
RESIDENCE <u>Nampa</u>	RESIDENCE <u>Nampa</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 2 a. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Metto Broadbent
Dr. Wm. Fink
(Physician or midwife)

Give names added from a supplemental report.

_____, 19____

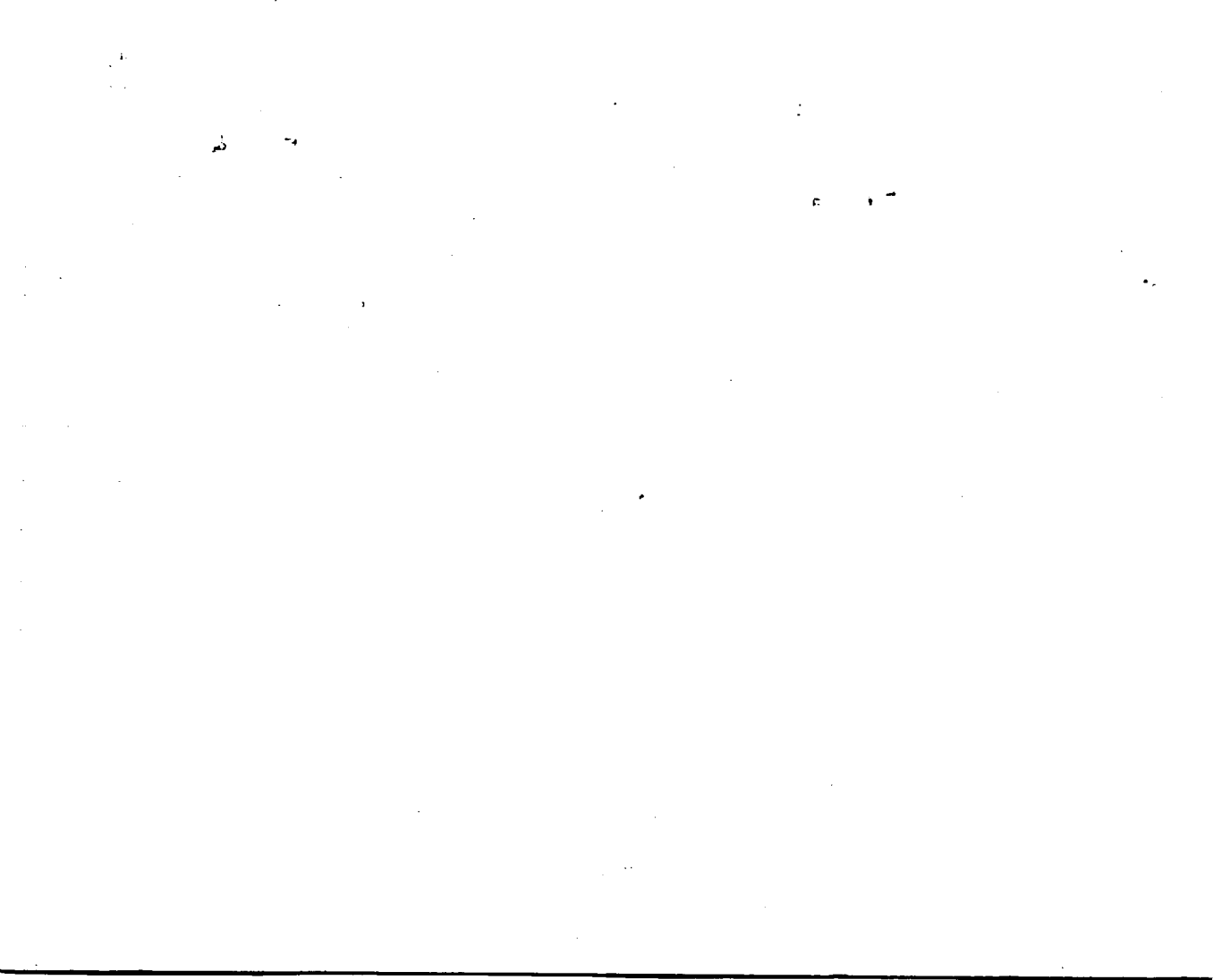
Registrar.

Address _____

Filed

Dec 4 1923 Pearle Dodds

Registrar.



1. PLACE OF DEATH

County of *Boyer*City of *Naupaka*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *7*Primary Registration District No. *1806*(No. *7*)St. *Idaho**Infant Philpott*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **43760**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov 10 1922
(Month) (Day) (Year)

7. AGE

*2 Yrs. 4 Mos. 2 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. M. Philpott

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Violet Hauck

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. M. Philpott
Naupaka, Ida

(Address)

15.

Filed

Dec. 4 1923 *Pearle Dodds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

about Nov 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

— 19..... to *—* 19.....
that I last saw him alive on *—* 19.....
and that death occurred on the date stated above, at *?* M.

The CAUSE OF DEATH* was as follows:

*attributed to long eye risk
one week prior to delivery.*
(Duration)..... Yrs..... mos..... ds.Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

*M. D. Fink**Dec 3 1923*

(Address)

Naupaka, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kokshupur *11-11-1923*

20. UNDERTAKER

ADDRESS

F. H. Johnson *Naupaka*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative helpfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

715-115-020-391

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

DEC 7 1923

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

County of Elmore

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

City of Idaho Falls

Registration District No. 34

File No. S 116943

No. _____ St. _____

Primary Registration District No. 2020

Registered No. 43

Hospital _____

FULL NAME OF CHILD

Pedro E. Gaudiago

Sex of Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

Legit
mate?

yes

Date of
Birth

Nov 15 23
(Month) (Day) (Year)

FULL
NAME

Eusebio Gaudiago

FATHER

FULL
MAIDEN
NAME

Centonia Tratorra

MOTHER

RESIDENCE

Idaho Falls

RESIDENCE

Idaho Falls

COLOR

White

AGE AT LAST
BIRTHDAY

33
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

25
(Years)

BIRTHPLACE

Spain

BIRTHPLACE

Spain

OCCUPATION

Sheepman

OCCUPATION

Housewife

Number of child of this mother, including present birth 4

Number of children of this mother now living including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Stillborn - 5 mo., at 4-30 P.M.
(Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

D. P. Hamilton
Physician

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Idaho Falls

Filed

Nov. 26 1923

Registrar

Registrar

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho Dec 12 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

* * * * *

Place of Birth (CITY Mountain Home FILE NO. 116943
(ST. Atlanta Ave DATE OF BIRTH Nov 16 - 1923
(COUNTY Elmore SEX OF CHILD Male
FATHER Eusebio Gandia MOTHER Antonina Grastosa
(Maiden Name)

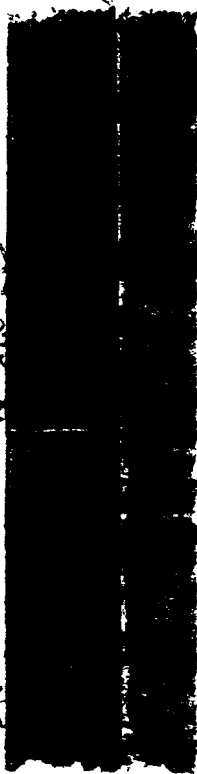
I HEREBY CERTIFY that the child herein described has been named:

Pedro J. Gandia

Eusebio Gandia Antonina Grastosa
Signature of Father or Mother.

DEC 13 1923
BUREAU OF VITAL STATISTICS

1977
FEB



[Faint, mostly illegible text and horizontal lines, possibly representing a document or form.]

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many.....hrs.

or.....min.?

Yrs.....Mos.....ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1923, to Nov. 16, 1923

that I last saw him alive on Premature Birth, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth 5 mos.

(Duration) Yrs.....mos.....ds.

Contributory (Secondary)

(Duration) yrs.....mos.....ds.

(Signed)

11-17-23 (Address) Inter. Home, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs.....mos.....days. In the State yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Int. Home Ida

11-17-1923

20. UNDERTAKER

ADDRESS

Wm Mc Bratney

Bess Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

213.228.026-695

PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of JeffersonCity of Bigby

No. _____ St. _____

Registration District No. 98File No. 117012

Hospital _____

Primary Registration District No. 2176Registered No. 207

FULL NAME OF CHILD

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>Yes</u>	Date of Birth <u>Oct 28</u> 19 <u>23</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	------------------------	--

FULL NAME <u>Lanida Bates</u>	FATHER	FULL MAIDEN NAME <u>Vivsey Kinder</u>	MOTHER
RESIDENCE <u>Proctor</u>		RESIDENCE <u>Bigby</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Wamsht. Wab</u>		BIRTHPLACE <u>Rich. Field Wab</u>	
OCCUPATION <u>Fairmer</u>		OCCUPATION <u>House Wife</u>	

Number of child of this mother, including present birth 16 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at 10.40 a.m.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mary Godfrey Stoddard

(Physician or midwife)

Given names added from a supplemental report.

Address Bigby IdahoFiled Nov 10 23Registar. Ray H Fisher

Registar.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

RECEIVED
NOV 10 1923
BUREAU OF VITAL STATISTICS
MEDICAL CERTIFICATE OF DEATH

Registration District No.

Primary Registrar District No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

Oct 29 1923

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

556-125-026-3K5
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 117013

County of Jefferson
City of Labelle
Registration District No. 98 File No. 212
No. 2176 St. Clinton Newbold (wishes)
Hospital home Primary Registration District No. 2176 Registered No. 212
FULL NAME OF CHILD Clinton Newbold (wishes)

Sex of Child m Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of Birth 10-25-23
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER
FULL NAME Andrew C. Newbold
RESIDENCE Labelle
COLOR White AGE AT LAST BIRTHDAY 43
(Years)
BIRTHPLACE Davenport
OCCUPATION farmer
WHAT BACTERIOLOGICAL TESTS WERE MADE IN EYES?

MOTHER
FULL MAIDEN NAME Emma M. Newbold
RESIDENCE Labelle
COLOR White AGE AT LAST BIRTHDAY 31
(Years)
BIRTHPLACE Labelle
OCCUPATION home

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 10:00 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O. Z. C. M. M.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

Nov 10 23

Registrar.

Registrar.

ВЕРИТЕ, ЧТО НАМ НЕ ПОДДАВАЮТ НИ ОДНОГО ИЗ НАС. А КАКИМ ОБРАЗОМ МЫ БУДЕМ ПЛАКАТЬ, ЕСЛИ ОН НЕ ПОДДАЕТСЯ НАШЕМУ ПЛАЧУ? И ЕСЛИ ОН НЕ ПОДДАЕТСЯ НАШЕМУ ПЛАЧУ, ТО КАКИМ ОБРАЗОМ МЫ БУДЕМ ПЛАКАТЬ, ЕСЛИ ОН НЕ ПОДДАЕТСЯ НАШЕМУ ПЛАЧУ?

44-38861-100

Registration No.

0379Jc1490

Primary Registration District No.

Full Name of Child

to x22
b11c

(To be answered only in event of direct inquiries)
 or other
 Tipton
 Twin
 and
 in order
 Number

MOTHER

NAME
MAIDEN
FULL

RECEIVED

SECRET

03103

YACHTS
AT LAST

000000

TRAJ TA ZDA
YACHTERIE

INSTRUMENT

COUNTRY

0000000000

NOITAHUCCO

Number of child of this mother. (Indicate present and

CERTIFICATE OF A TENDING PHYSICIAN AND MIDWIFE.

new copy, it is said, that I am not a member of the club.

70 names of the persons who were in the room at the time of the shooting. The names of the persons who were in the room at the time of the shooting are as follows:

Hogor ~~Sakuragawa~~ = meg? babba sounn xevit?

42-5766 A.

11

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of cr

STATE OF IDAHO

No. 98

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33501

Registered No. 44

County of Adair Registration District No. 2176 St. Idaho

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

10 - 25 - 1923
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF
FATHERAndrew B. Newbold11. BIRTHPLACE
OF FATHER(State or Country) Utah12. MAIDEN NAME
OF MOTHEREmma Lundquist13. BIRTHPLACE
OF MOTHER(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Newbold(Address) Libelle, Ida15. New 10-23Filed 19Regis. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 - 25 - 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) D. L. Hall M. D.10-26-23 (Address) Regis. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "*Epidemic cerebrospinal meningitis*"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "*Typhoid Pneumonia*"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *pertussis*, etc.; "*Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "*Cancer*" is less definite; avoid use of "*Tumor*" for malignant neoplasms; *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "*Debility*," "*Congestive*," "*Senile*," "*Coma*," "*Convulsions*," "*Dropsey*," "*Exhaustion*," "*Heart failure*," "*Hemorrhage*," "*Insanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uræmia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL. Examples: *Accidental drowning*; *struck by railway train*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer*, *Physician*, *Stenographer*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "*Labourer*," "*Foreman*," "*Manager*," "*Dealer*," etc., without more precise specifications, as *Day labourer*, *Farm labourer*, *Labourer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

893-219-028-982

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

117017

County of

City of

No.

Hospital

Primary Registration District No.

File No.

Registered No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child

Twin
Triplet
or other?

{ and }

{ Number
in order
of birth }Legiti-
mate?Date of
birth

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

at

M.

(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Give names added from a supplemental report.

Address

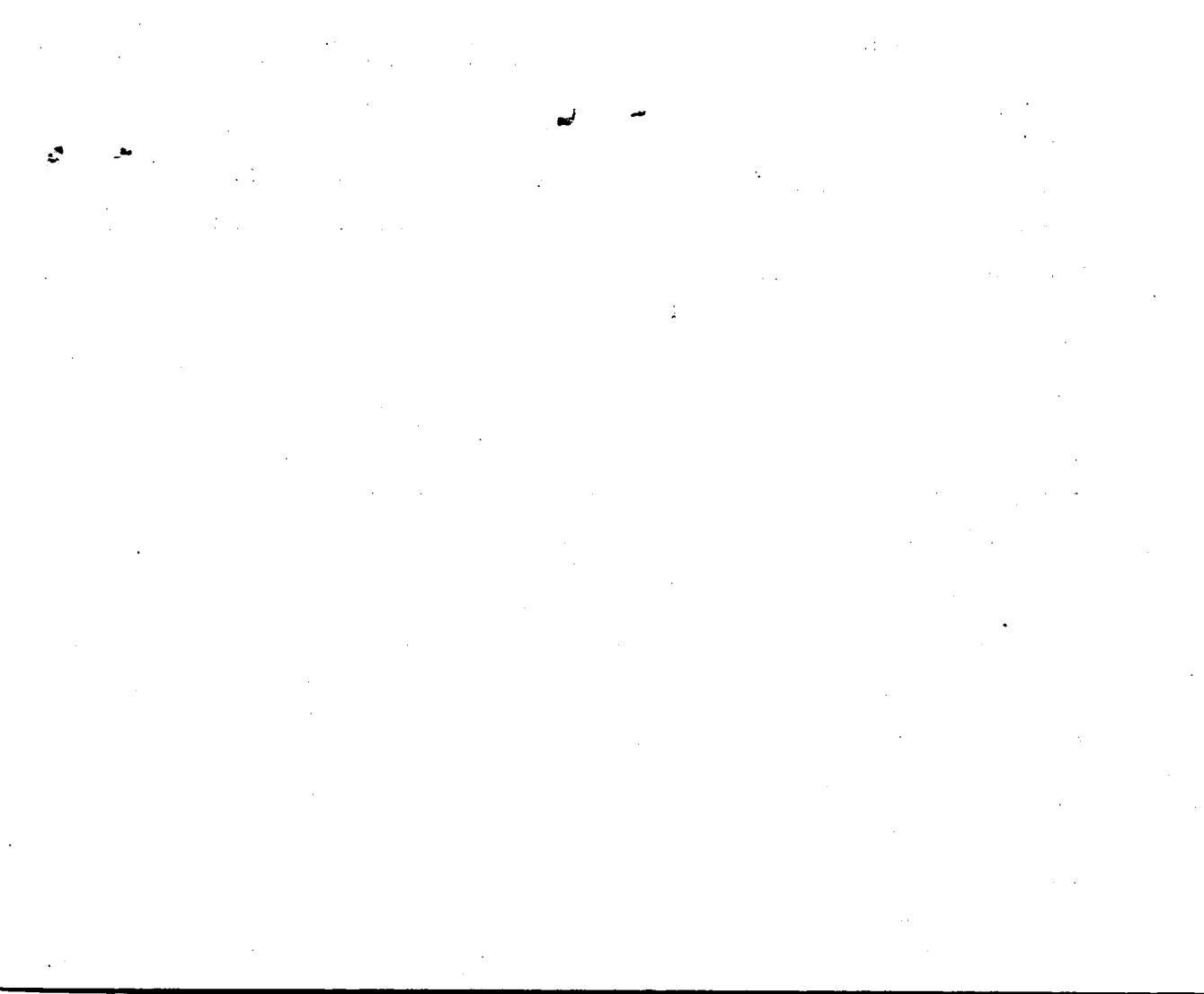
Filed

1923

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

43815

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Boone* Registration District No. *126*
City of *Springfield* Primary Registration District No. *2204*
St.) Registered No. *29*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still Born. 7 months gestation Hicks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.)

6. DATE OF BIRTH.

10 - 28 1923
(Month) (Day) (Year)

7. AGE

7 mo gestation

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Grant Hicks

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Rosie Ryser

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Grant Hicks

(Address)

Springfield, Ida

15.

Filed

10 - 30 1923

19

H. J. J. J.

Local Registrar

16. DATE OF DEATH

10 - 29 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....
that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Extreme cerebral edema of mother

(Duration) *Still born* Yrs. mos. ds.
Contributory (Secondary)

(Signed) *J. H. J. J.* M. D.
10-21-23 (Address) *Harmon*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harmon *10-22 1923*

20. UNDERTAKER

ADDRESS

Assisted by Mrs. P. J. J. J. *Harmon*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

694-124.021-219
PLACE OF BIRTHCounty of LewisCity of Nezperce IdahoNo. Route 21 St.

Hospital _____

FULL NAME OF CHILD _____

RECEIVED

NOV 15

BUREAU OF VITAL

Registration No. 47IDAHO
STATISTICS
BIRTH

S

Form V. S. No. 11-C-25m-9-8-16

File No. 117101

Primary Registration District No. _____

Registered No. 231

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth 1	Legitimate? <u>Yes</u>	Date of Birth <u>Oct 4</u> 19 <u>23</u> (Month) (Day) (Year)
--------------------------	---	---	---------------------------	---

FULL NAME <u>James Wimpy</u>	FATHER
RESIDENCE <u>Nezperce</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>Wash</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Mary Bell Barbe</u>	MOTHER
RESIDENCE <u>Nezperce</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Wash</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth none

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Dead at 9 P. M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. Taylor M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address

Filed

Albas Huff
Registrar
Nezperce Idaho
Nov 12 1923
Albas Huff
Registrar

STATE OF
BIRTH

PLACE OF BIRTH

DATE OF BIRTH

FULL NAME OF CHILD

SEX OF CHILD

FATHER

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

RESIDENCE

JOE A. LEST
BIRTHDAY

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

When the child is born, the attending physician or midwife should fill out this certificate and forward it to the local health department. This certificate is required for the child to be registered for birth.

THIS IS TO CERTIFY THAT THE CHILD OF JOE A. LEST AND MARY LEST, BORN ON [DATE], AT [PLACE], IS THE LEGITIMATE CHILD OF THE MARRIED COUPLE OF JOE A. LEST AND MARY LEST, AND THAT THE CHILD IS THE LEGITIMATE CHILD OF THE MARRIED COUPLE OF JOE A. LEST AND MARY LEST.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Lewis*City of *Nepune Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No. *47*Registration District No. *47*File No. *43524*Registered No. *98*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH.

Oct 4 1923
(Month) (Day) (Year)

7. AGE

*Stillborn*IF LESS than 1 day
how many.....hrs. or
.....min.2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nepune

10. NAME OF FATHER

James Wm. Wimpy

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Mable Mary Barber

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*James William Wimpy
Nepune Idaho*

15.

Filed *10-8-1923**Albert Huff*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct - 4 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
191..... to 191.....

that I last saw him..... alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed) *E. Taylor* M. D.19..... (Address) *Nepune Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

*Nepune Cemetery
Albert Huff**10-4-1923
Nepune Idaho*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

593-216-233-819
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
DEC 8 1923
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 117117

County of Madison
City of Reynolds
No. 2178 St. 100 Registration District No. 100 File No. 606
Hospital Primary Registration District No. 100 Registered No. 606

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other One and Number in order of birth — Legitimate? yes Date of birth 11 16 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME W B Nichols
RESIDENCE Reynolds Ida
COLOR White AGE AT LAST BIRTHDAY 34
(Years)
BIRTHPLACE Ogden Utah
OCCUPATION Bookkeeper

MOTHER
FULL MAIDEN NAME Ester Larnell
RESIDENCE Reynolds Ida
COLOR White AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E W Parkinson
Physician
(Physician or midwife)

Give names added from a supplemental report.
 , 19

Registrar.

Address
Filed 12/1 1923 J Young
Registrar.

CONFIDENTIAL

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho Dec 11 1923 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY _____	FILE NO. <u>117117</u>
	(ST. _____	DATE OF BIRTH _____
	(COUNTY _____	SEX OF CHILD <u>Female</u>
	FATHER _____	MOTHER _____
		(Maiden Name) _____

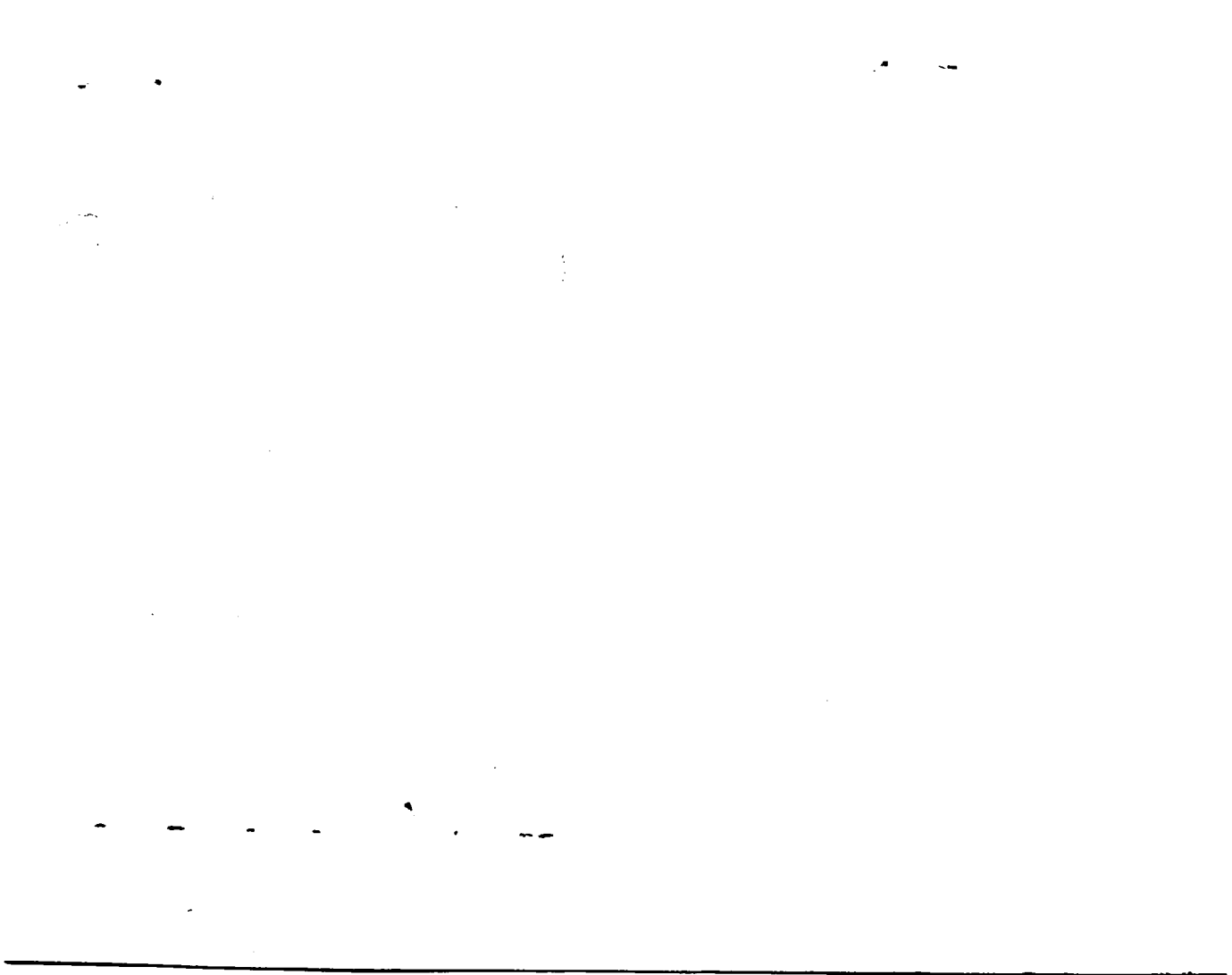
I HEREBY CERTIFY that the child herein described has been named:

The baby was still born and therefore
no name given

B. Nichols

Signature of Father or Mother.

RECEIVED
DEC 11 1923



FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. JAN 5 1923
 Registration District No. 100
 County of Madison Primary Registration District No. 2178
 City of Rexley (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Nichols

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 44158

Registered No. 137

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED.

F.

W.

Still Born

(Write the word.)

6. DATE OF BIRTH.

Nov.

16

1923

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rexley Idaho

10. NAME OF FATHER

G. B. Nichols

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Esther Howell

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

G. B. Nichols

(Address)

Rexley Idaho

15.

Filed

11/17

19123

J. R. Gandy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.

16

1923

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 16

1923

to Nov. 16

1923

that I last saw ~~her~~ alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Parkinson M. D.

19 (Address) Rexley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rexley

11/17 1923

20. UNDERTAKER

ADDRESS

J. R. Gandy

Rexley

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1057a

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

154-106:035-154
PLACE OF BIRTH

County of Reg. Perce
City of Lapwai

RECEIVED
1923

BUREAU OF VITAL STATISTICS

S

No. _____ St. Registration District No. 97 State File No. 117169
Hospital _____ Primary Registration District No. 2174 Local Registrar's No. 13

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? no Date of birth Nov 6 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth none

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY
(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY
(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at #45 a. m.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed Nov 10 1923

Registrar.

Registrar.

STATE OF NEW YORK
 COUNTY OF ALBANY
 I, the undersigned, being a duly qualified Justice of the Peace for the County of Albany, do hereby certify that the within and foregoing is a true and correct copy of the original report of the Registrar of the County of Albany, as the same appears from the records of said County.

PLACE OF BIRTH

CHILD'S NAME

SEX OF CHILD

What particular condition was used in eyes

Number of still of this mother, including present birth

FATHER
 FULL NAME

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

DATE OF BIRTH

COLOR

BIRTHPLACE

OCCUPATION

RESIDENCE

FULL NAME
 MOTHER

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at _____ on the _____ day of _____, 19____.

"When there was no attending physician or midwife, then the father, grandfather, or uncle, or other person, or persons, who were present at the birth, should make this report. A stillborn child is one that neither breathes nor shows other evidence of life at birth. (The names added from a supplemental report.)"

19____

Registrar

Filed

19____

Registrar

(Signature of Registrar)

(Signature)

born at _____

at _____

DATE OF BIRTH

CERTIFICATE OF BIRTH

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

1. PLACE OF DEATH.

County—of Nez Perce
City of Lapwai

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrews

CERTIFICATE OF DEATH.

Registration District No. 99
Registration District No. 2174
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43839
Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

MaleBrown

(Write the word.)

6. DATE OF BIRTH.

Nov 661923

(Month)

(Day)

(Year)

7. AGE

Still born

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Lapwai Ida

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mellie Andrews

13. BIRTHPLACE OF MOTHER

(State or Country)

Lapwai

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

L. F. Smith M.D.

(Address)

Lapwai

15.

Filed

Nov 10192311:14

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov61923

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Still born
Full term
Cause of death unknown

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted

if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lapwai191

20. UNDERTAKER

ADDRESS

none

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

349-112-04-462
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Teton RECEIVED
City of Victor DEC 3 1923
No. Sup. Registration 108 District No. 77 State File No. 117223
Hospital _____ Primary Registration District No. 2176 Local Registrar's No. 91

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>Aug-12th</u> 192 <u>3</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? 2

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME FATHER
Leo B. Curtis
RESIDENCE Victor
COLOR white AGE AT LAST BIRTHDAY 29
(Years)
BIRTHPLACE Victor
OCCUPATION farming

FULL MAIDEN NAME MOTHER
Miss Ruby Mose
RESIDENCE Victor
COLOR white AGE AT LAST BIRTHDAY 31
(Years)
BIRTHPLACE Mt Pleasant Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Victor M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1923

(Signature) Chas. Martin
Physician
(Physician or midwife)

Address Victor, Idaho
Filed 11-30- 1923 Martha Marker
Registrar.

Registrar.

Registrar.

22

22

22

22

22

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Teton*
City of *Victor*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *72*Primary Registration District No. *2176*

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *44302*Registered No. *32*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Unnamed*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Single*
(Write the word.)

6. DATE OF BIRTH

November 20 *1923*
(Month) (Day) (Year)

7. AGE

Stillborn
Mos. _____ ds. _____IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Leo B. Curtis

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ruby Mess.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leo B. Curtis

(Address)

Victor Idaho

15.

Filed *Dec 16-1923**Martha Marker*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 20-1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov 20-1923 to *Nov 20-1923*that I last saw him in *Stillborn* 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas. J. Martin M. D.*11/20/1923*(Address) *Driggs, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Victor Idaho

DATE OF BURIAL

11/21/1923

20. UNDERTAKER

ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

613-244-795-
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Washington NOV

City of Weiser BUREAU

No. _____ St. _____

Registration District No. _____

File No. 117254

Hospital _____

Primary Registration District No. 2112

Registered No. 40

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>10-15</u> 19 <u>23</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 7 Number of child of this mother now living, including present birth... 4

FATHER
FULL NAME Millard J. Wallace
RESIDENCE Weiser Idaho
COLOR white AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Mt. City Tenn.
OCCUPATION Labour

MOTHER
FULL MAIDEN NAME Flora Greer
RESIDENCE Weiser Idaho
COLOR white AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Trade Tenn.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 9:50 P. M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

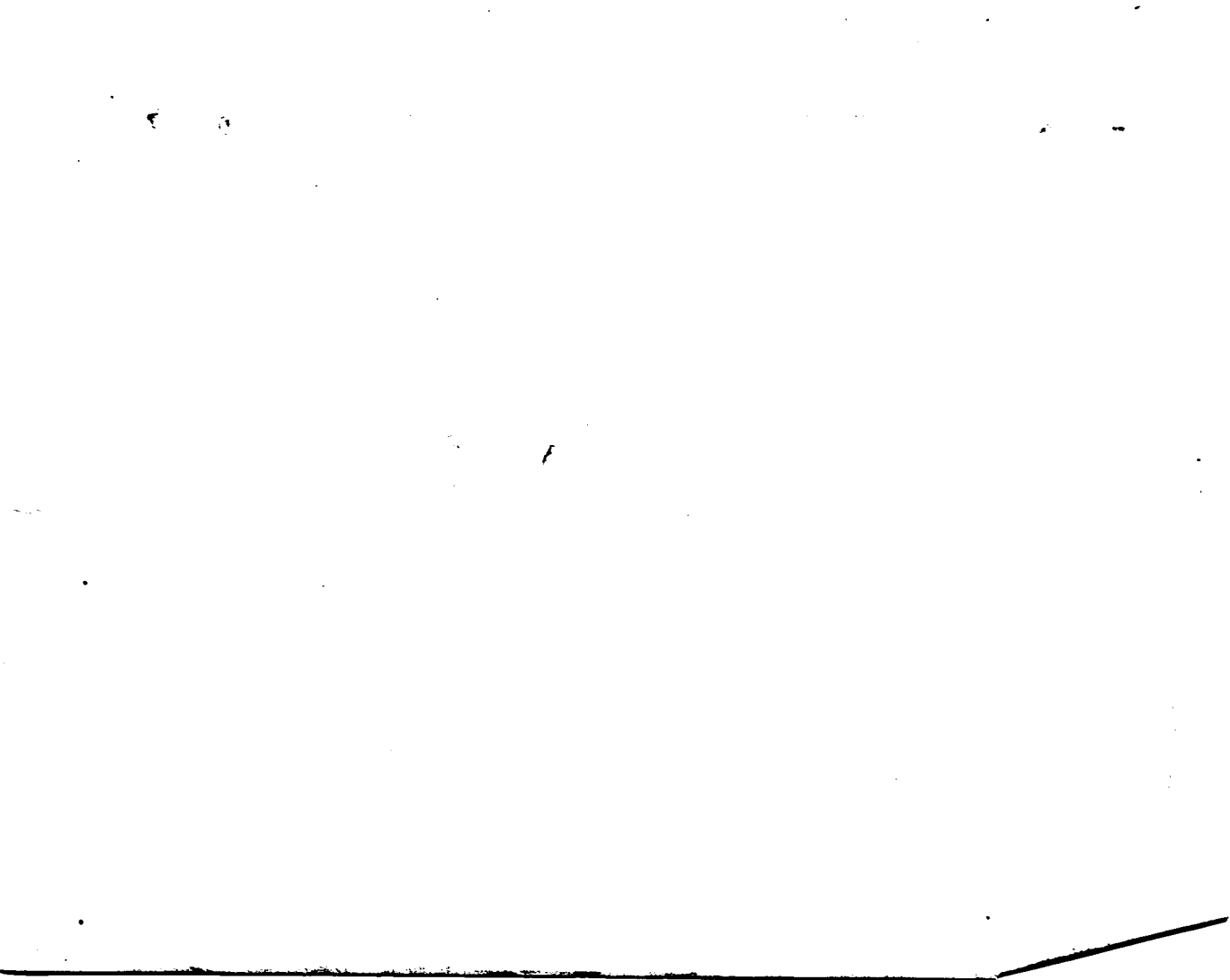
(Signature) Ornest O. Finney
Physician
(Physician or midwife)

Give names added from a supplemental report. _____, 19____

Address _____

Filed Nov 15 1923 W. R. Hannah
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 43864
Registered No. 17

1. PLACE OF DEATH

County of Washington
City of Okeechobee
Primary Registration District No. 2112
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS
Baby Wallace

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female whr (Write the word.)

6. DATE OF BIRTH

Oct 15 23
(Month) (Day) (Year)

7. AGE

2 tie born
Yrs Mos ds IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Millard Wallace

11. BIRTHPLACE OF FATHER

(State or Country) Texas

12. MAIDEN NAME OF MOTHER

Theresa Greer

13. BIRTHPLACE OF MOTHER

(State or Country) Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Millard Wallace

(Address)

15. Filed Oct-16 1923 E. R. Haulm Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 15 th. 19 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/13/23 19 to 10/15/23 19
that I last saw her alive on Still birth 19
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Maternal Hemorrhage during delivery.

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ernesto F. Fungui M. D.

10/16 19 23 (Address) Weiser Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hillcrest Cemetery 10-16 19 23

20. UNDERTAKER ADDRESS

Northam McCann Weiser Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. H.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

239-121-201-415
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada
City of Barker

RECEIVED

CERTIFICATE OF BIRTH

117283

No. 2 Registration District No. 2 State File No. 117283

Hospital St. Luke's Primary Registration District No. 1004 Local Registrar's No. 380

FULL NAME OF CHILD Frank Stiles
(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>11/21</u> , 19 <u>23</u> (Month) (Day) (Year)
-----------------------	-----------------------------------	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? None - Stillborn

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FULL NAME <u>FATHER</u> <u>Harold Stiles</u>	FULL NAME <u>MOTHER</u> <u>Ora Daniell</u>
RESIDENCE <u>Barker Idaho</u>	RESIDENCE <u>Barker Idaho</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Indiana</u>	BIRTHPLACE <u>Miss</u>
OCCUPATION <u>Contractor</u>	OCCUPATION <u>HW</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Home-born Stillborn at 18 42 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return.
A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Edward Thier MD

Give names added from a supplemental report.

(Physician or ~~midwife~~) Barker Idaho

Address Barker Idaho

File Dec 15 1923 R. S. Pratt

Registrar.

Registrar.

THIS CERTIFICATE IS TO BE FILED IN THE BIRTH RECORDS OF THE COUNTY OF HENRY, MISSOURI, AND IN THE BIRTH RECORDS OF THE STATE OF MISSOURI. IT IS TO BE KEPT IN THE BIRTH RECORDS OF THE COUNTY OF HENRY, MISSOURI, AND IN THE BIRTH RECORDS OF THE STATE OF MISSOURI, FOR A PERIOD OF FIFTY YEARS.

2

11-1-1903

STATE OF MISSOURI
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____

Registration District No. _____

State File No. _____

Hospital _____

Physician Registration District No. _____

Local Registrar's No. _____

FULL NAME OF CHILD _____

Sex of Child _____

Color _____

Birthplace _____

Age at last birthday _____

Occupation _____

Birthplace _____

Age at last birthday _____

Occupation _____

Number of child in this mother's family, including present birth _____

Number of child in this mother's family, including present birth _____

FATHER'S FULL NAME _____

MOTHER'S FULL NAME _____

RESIDENCE _____

RESIDENCE _____

DATE OF BIRTHDAY _____

DATE OF BIRTHDAY _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____

(Signature) _____

At _____

On the _____ day of _____

When there was no attending physician or midwife, then the father, mother, etc., should make this return. A physician's certificate is not required unless it shows other evidence of life after birth.

Give name and address of a supplemental report.

Address _____

Physician _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Ada
City of Burton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. 116 East Burton St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 43662
Registered No. 256

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Baby Sities

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Nov 21 1923
(Month) (Day) (Year)

7. AGE Still born
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Boone Ia
(State or Country)

10. NAME OF FATHER H. L. Sities

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Ora Daniels

13. BIRTHPLACE OF MOTHER Miss
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. L. Sities
(Address) Barber Ida

15. Filed Nov 22 1923 R. H. Cook
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 21 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19
that I last saw him alive on 19
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Still birth

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Edmund H. Ramsey M. D.
11/23 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Barber, Idaho

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 11/22 1923

20. UNDERTAKER Schubert Wideman ADDRESS Boone Ia

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

445-2007-001-664
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada
City of Boise
No. 117285 State File No. 117285
Hospital St. Alphonsus Registration District No. 1004 Local Registrar's No. 382
FULL NAME OF CHILD Baby Newman
(Certificate of no value without full name of child.)

Sex of Child 7 Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth Dec 7th, 1923
(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Edgar B. Newman
RESIDENCE Boise
COLOR White AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Oregon
OCCUPATION Univ. Ext. Service

MOTHER
FULL MAIDEN NAME Raura Foulds
RESIDENCE Boise
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Iowa
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2:15 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Joseph P. Newman
(Physician or midwife)

Address Boise, Idaho
Filed Dec 15, 1923 P.H. Pax
Registrar.

CONFIDENTIAL

10 vjED

Estimated Registration District No. 1 Local Registrar's No. 1

(Indicate of no value without full name of child)

[illegible]

11-11-61

Number of child of this mother, including present birth

NAME	RESIDENCE	NAME	RESIDENCE
Fuller	13	Fuller	13
MAIDEN NAME	RESIDENCE	MAIDEN NAME	RESIDENCE
Fuller	13	Fuller	13
FATHER	RESIDENCE	FATHER	RESIDENCE
Fuller	13	Fuller	13
MOTHER	RESIDENCE	MOTHER	RESIDENCE
Fuller	13	Fuller	13

COLOR AGE AT LAST BIRTHDAY	COLOR AGE AT LAST BIRTHDAY
----------------------------------	----------------------------------

BIRTHPLACE

100-443888-100

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

1. I have never seen any of the children of the family of the late Mrs. J. H. H. who was born in 1812 and died in 1882. I have never seen any of the children of the family of the late Mrs. J. H. H. who was born in 1812 and died in 1882.

* When there was no attending physician or midwife, the father, husband or mother should make this return. A newborn child is one that has first been born.

It is not shown what evidence to

Give names and addresses of persons who report.

(Physician or Midwife)

(ကျေးဇူးတင်စွာ)

2015A

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada, ID.City of Boise, ID.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2Primary Registration District No. 1004(Not to be filled in by the Registrar) St. Alphonsus HospitalFile No. 43886Registered No. 321

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Duncan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Dec - 7 - 1923
(Month) (Day) (Year)7. AGE — Yrs. — Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None.

9. BIRTHPLACE

(State or Country)

Boise, Idaho.

10. NAME OF FATHER

E. B. Duncan

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon.

12. MAIDEN NAME OF MOTHER

Laura E. Foulds

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. Bratney
Boise, Idaho.15. Filed Dec 8 1923Local Registrar R. R. Crady

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec - 7 - 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1923 to Dec 7 1923, that I last saw him alive on Dec 7 1923, and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:
Premature (6 mo.)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Newman M. D.
12/7/1923 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Hill Cemetery12/8 1923

20. UNDERTAKER

ADDRESS

Wm. BratneyBoise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

562-228-007-551
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine

City of Pocatello

No. 335

St.

BUREAU

Registration

District No. 28

State File No. 117449

Hospital

Primary Registration District No. 2161

Local Registrar's No. 6236

FULL NAME OF CHILD Marion Jean Noble

(Certificate of no value without full name of child)

Sex of Child Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate? Yes

Date of
birth Dec 28 1923

(Month) (Day) (Year)

What bactericidal solution was used in eyes? Cryophyl

Number of child of this mother, including present birth 9

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR White

AGE AT LAST
BIRTHDAY 45

(Years)

COLOR White

AGE AT LAST
BIRTHDAY 42

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 500 M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

Address

Filed

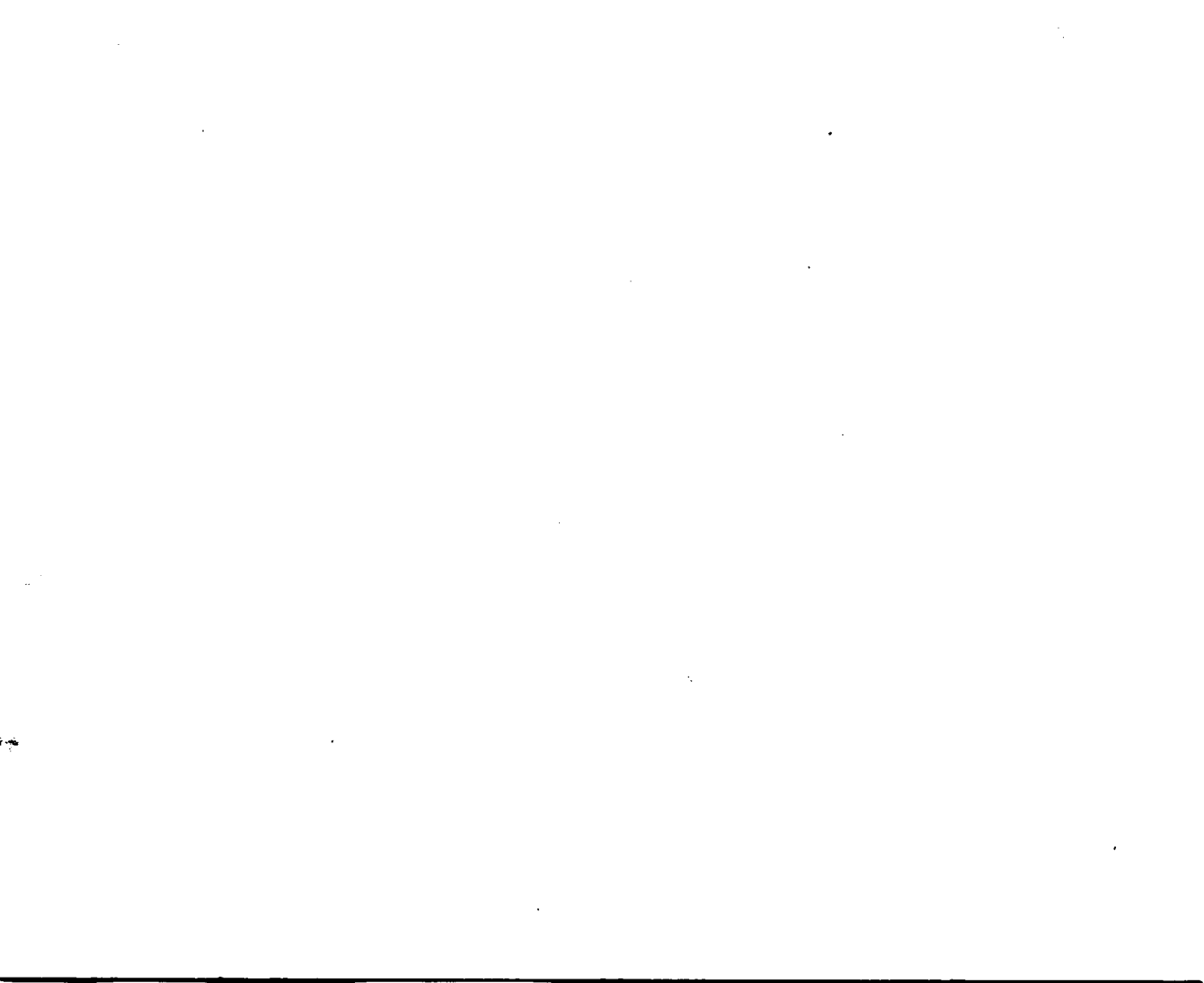
W. N. Haddon

(Physician or midwife)

Pocatello Idaho

1-1 1924

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated

238-112 000-24

PLACE OF BIRTH

County of Bear Lake

City of Paris

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD _____

RECEIVED

DEC 20 1915

BUREAU OF STATISTICS

STATE OF IDAHO

Bureau of Vital Statistics

CERTIFICATE OF BIRTH

S

Registration District No. 52

File No. _____

117462

Primary Registration District No. 2136

Registered No. _____

Sex of Child <u>Male</u>	Twin, Triplet, or other? _____	and Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>10 - 12 1915</u> (Month) (Day) (Year)
FULL NAME FATHER <u>H. G. Schick</u>		FULL MAIDEN NAME MOTHER <u>Mary Gauss</u>		
RESIDENCE <u>Paris</u>		RESIDENCE <u>Paris</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	
BIRTHPLACE <u>Paris</u>		BIRTHPLACE <u>Germany</u>		
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Wife</u>		

Number of child of this mother, including present birth. 1

Number of children, of this mother, now living, including present birth. 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10 a.m. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____

Geo. J. Ashley
Physician
(Physician or Midwife)

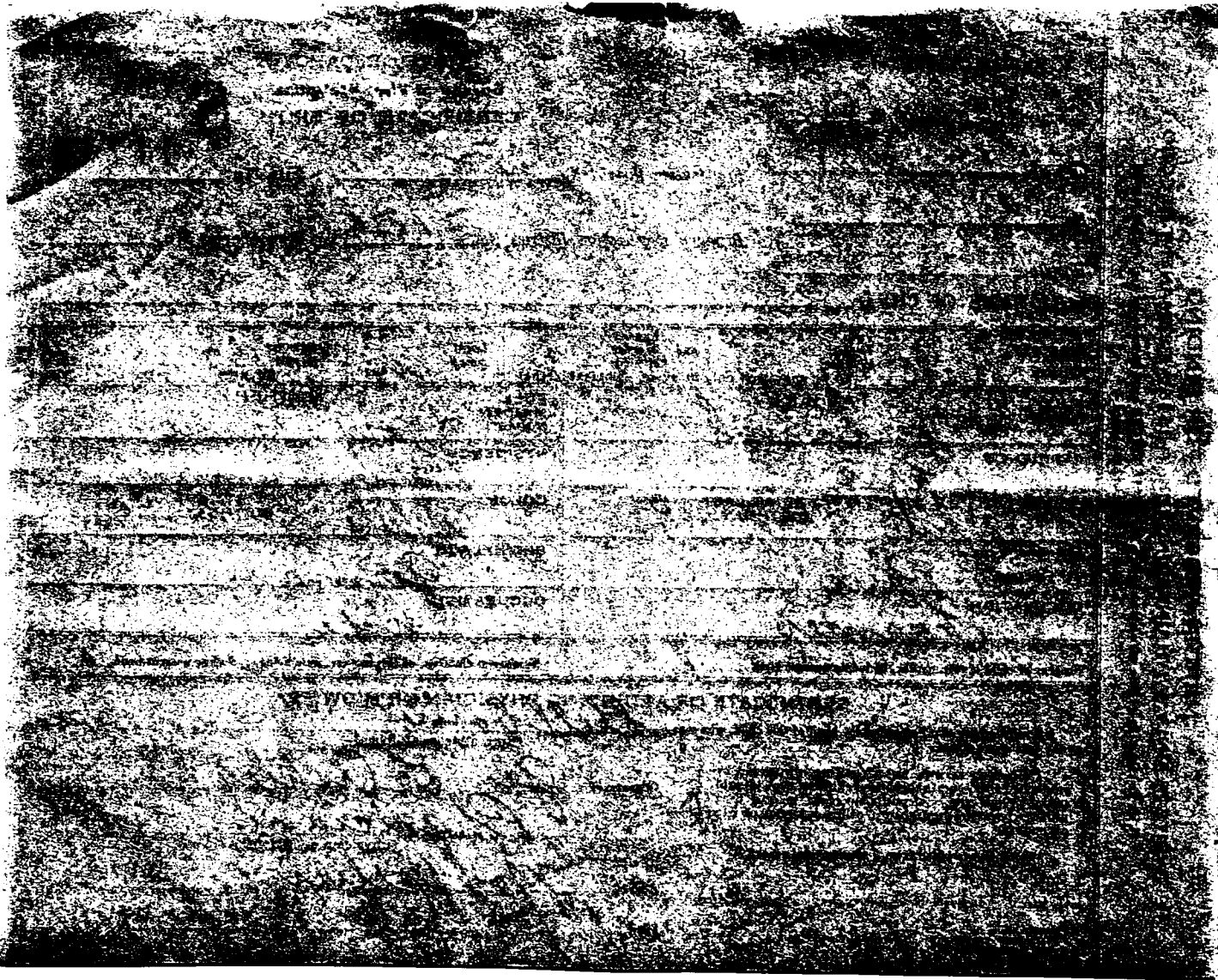
Given names added from a supplemental report

Address _____

Filed _____

Mossipeli
12/15/15
Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

43396 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
Registration District No. 53
County of Bear Lake
City of Paris
File No. 51
Registered No.

1. PLACE OF DEATH

County of Bear Lake
City of Paris

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Waley Schick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH October 12 1923
(Month) (Day) (Year)

7. AGE 8 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Working for railroad
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Paris Idaho.
(State or Country)

10. NAME OF FATHER Henry Charles Schick

11. BIRTHPLACE OF FATHER Paris Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER Marguerite Ganser

13. BIRTHPLACE OF MOTHER Lohrungen 27 Feb. 1891
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Schick.
(Address) Paris Idaho.

15. Filled Oct-22 1923 Mrs. J. Schick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 12 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Causes of death - Baby was still born.
(Duration) 19 23 (Address) 19 23
Contributory (Secondary) 19 23
(Duration) yrs mos ds.
(Signed) Dr. J. Schick M. D.

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days. In the State yrs mos days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Paris DATE OF BURIAL 10 14 19 23

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

231-267.004-397

PLACE OF BIRTH

County of Bear LakeCity of Georgetown

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD _____

RECEIVED
DEC 20 192
BUREAU OF VIT.
STATISTICS
Registration District No. _____Primary Registration District No. 2136

STATE OF IDAHO

Bureau of Vital Statistics

CERTIFICATE OF BIRTH

Form V. S. No. 11-C—15m-6-20-11

S
117464

File No. _____

Registered No. _____

Sex of Child <u>girl</u>	Twin, Triplet, or other? _____	and } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>10-17-23</u> (Month) (Day) (Year)
FATHER FULL NAME <u>A. M. Black</u>		MOTHER FULL MAIDEN NAME <u>Alice Lippitt</u>		
RESIDENCE <u>Georgetown</u>		RESIDENCE <u>Georgetown</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>33-</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	
BIRTHPLACE <u>Georgetown</u>		BIRTHPLACE <u>Georgetown</u>		
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Wife</u>		
Number of child of this mother, including present birth <u>5</u>		Number of children, of this mother, now living, including present birth <u>4</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

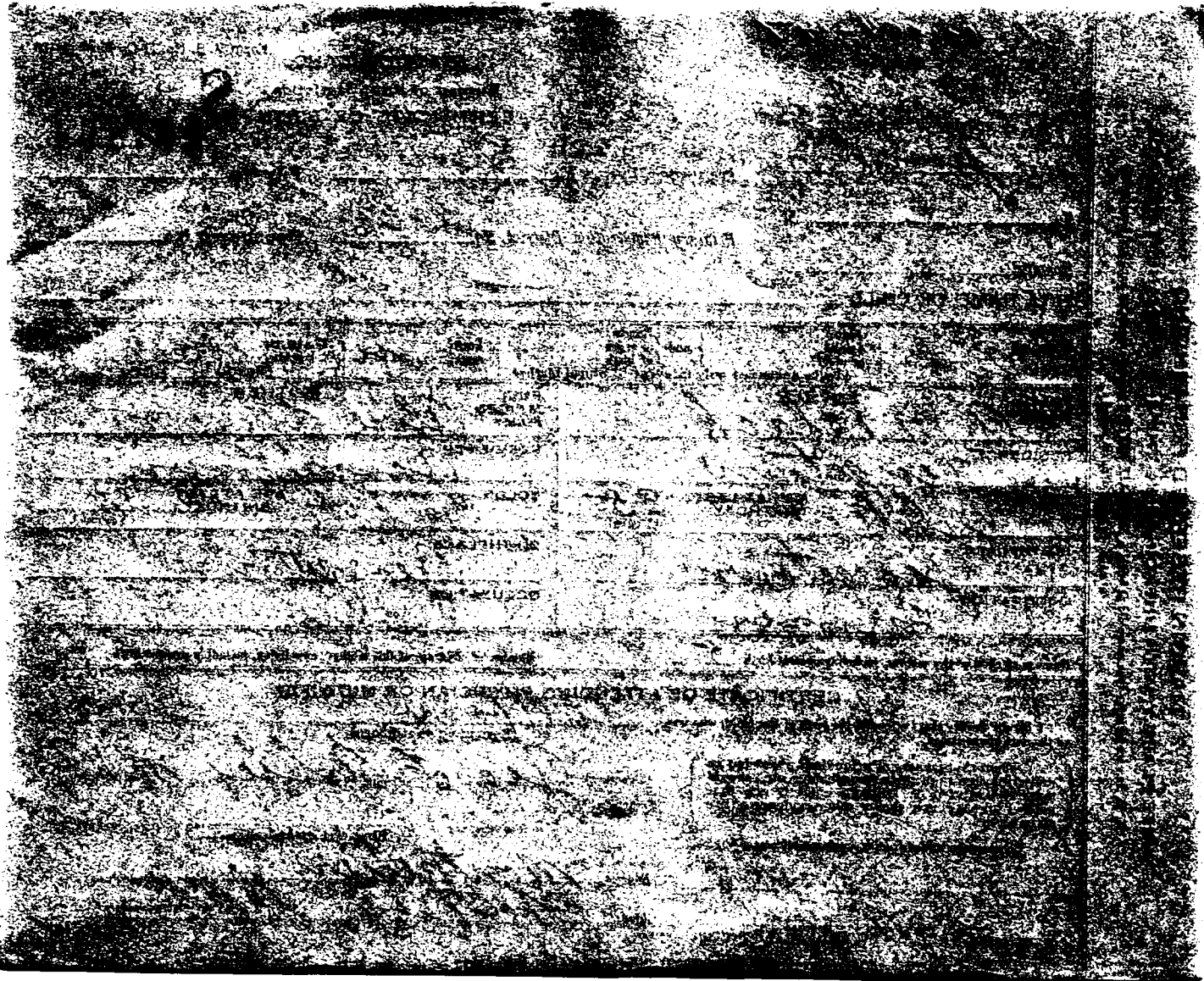
I hereby certify that I attended the birth of this child, who was Stillborn, at 7 a. M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Geo. F. Ashley M.D.
(Physician or midwife)

Given names added from a supplemental report

Address Montpelier
1215 1/2 23
Filed 12/15/23 19. H. H. H. H. Registrar



N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

213-110-004-135
PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-25m-4-8-15

S

County of Bear Lake

City of Montpelier

Registration District No. 52

CERTIFICATE OF BIRTH

File No. 117490

No. _____ St. 2136

Primary Registration District No. _____

Registered No. _____

Hospital _____

FULL NAME OF CHILD Galmer

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>12 10 1923</u> (Month) (Day) (Year)
FULL NAME <u>Ray Galmer</u>	FATHER		FULL MAIDEN NAME <u>Pearl McAlexander</u>	MOTHER
RESIDENCE <u>Montpelier</u>			RESIDENCE <u>Montpelier</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)		COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Ida.</u>			BIRTHPLACE <u>Kansas</u>	
OCCUPATION <u>Genl Mgr. U. P. & L. Co</u>			OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth. 3 Number of children of this mother now living, including present birth. 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9 P. M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. P. Gaertner

(Physician or midwife)

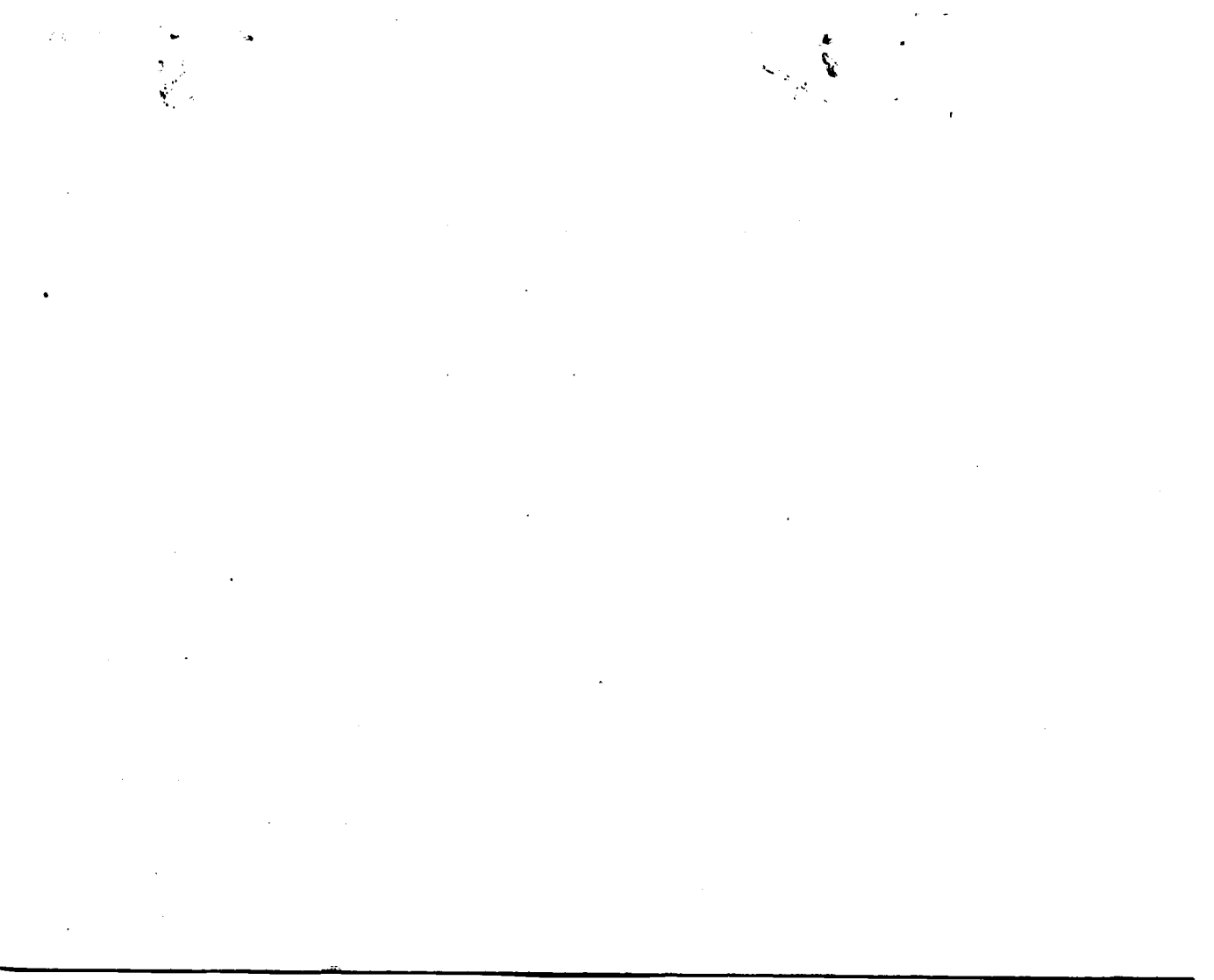
Given names added from a supplemental report.

Address Montpelier

Filed 12/15/23

Registrar

Registrar



FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

APR 8 1924
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44935

1. PLACE OF DEATH

County of Benav Lake
City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Bohmer

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDInfant
(Write the word.)

6. DATE OF BIRTH

Dec 10 1923
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many ____ hrs.
or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Stillborn

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ray Bohmer

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Pearl Mc Alexander

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ray Bohmer
Montpelier, Idaho

15.

Filed 1-1-24 MAH 19

Local Registrar

16. DATE OF DEATH

Dec 10 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 10 1923, to 19
that I last saw h. in Stillborn 19
and that death occurred on the date stated above, at ____ M.The CAUSE OF DEATH* was as follows: Birth turnStillborn

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

1/19/24 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Montpelier Idaho Dec 11 1923

20. UNDERTAKER

ADDRESS

Dr. Williams Montpelier

1123
42
76

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

513-101-006-562
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

JAN 3 1924

CERTIFICATE OF BIRTH

117526

County of Bingham

City of Blackfoot

No. Word 4 St.

Registration District No. 121

File No.

Hospital

Primary Registration District No. 1007

Registered No. 473

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of
Child

Male

Twin
Triplet
or other?

{ and }

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Dec. 1

1923

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Louis Naleo

FULL
MAIDEN
NAME

MOTHER

Reba B. Naleo

RESIDENCE

Blackfoot, Idaho

RESIDENCE

Blackfoot, Idaho

COLOR

mx

AGE AT LAST
BIRTHDAY

49

(Years)

COLOR

mx

AGE AT LAST
BIRTHDAY

23

(Years)

BIRTHPLACE

Mexico

BIRTHPLACE

Mexico

OCCUPATION

Laborer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

William at 9.9 M.
(Born alive or stillborn)

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

D. W. Matchell, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

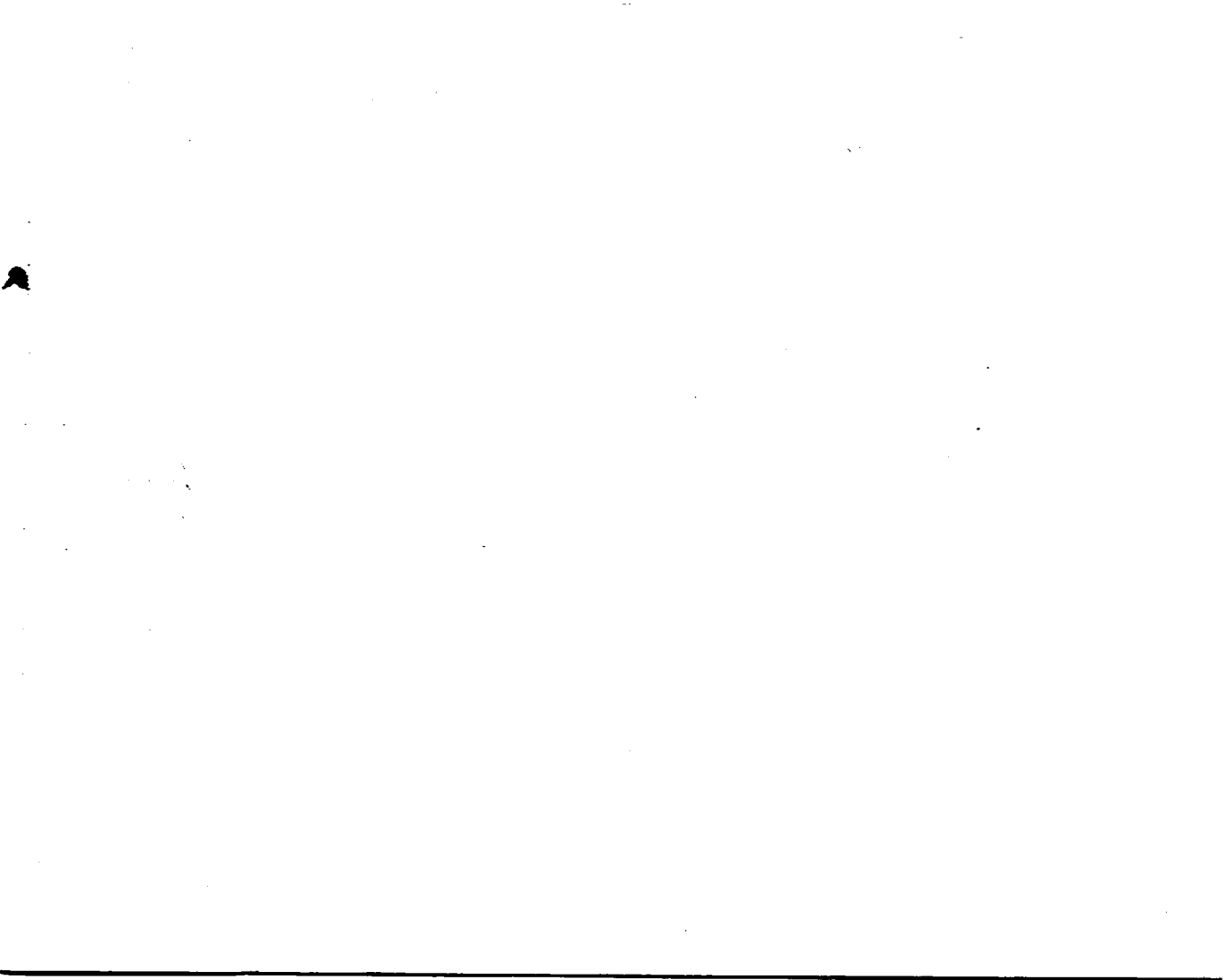
Blackfoot, Idaho

Filed

Jan 4, 1924

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

419-230-207-195
PLACE OF BIRTH

RECEIVED
JAN 3 1924
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine

City of Hailey

No. _____ St. _____

Registration District No. 57

File No. 117560

Hospital _____

Primary Registration District No. 2022

Registered No. 87

FULL NAME OF CHILD

Francis Dary

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth. <u>11</u> <u>30</u> <u>1923</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. 4 Number of child of this mother now living, including present birth. 3

FATHER
FULL NAME James Leroy Dary
RESIDENCE Hailey, Ida

MOTHER
FULL MAIDEN NAME Francis P. Arnold
RESIDENCE Hailey, Ida

COLOR White AGE AT LAST BIRTHDAY 36
(Years)

COLOR white AGE AT LAST BIRTHDAY 23
(Years)

BIRTHPLACE Hailey, Ida

BIRTHPLACE Hailey, Ida

OCCUPATION Laborer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated. (Born alive or stillborn) _____ M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

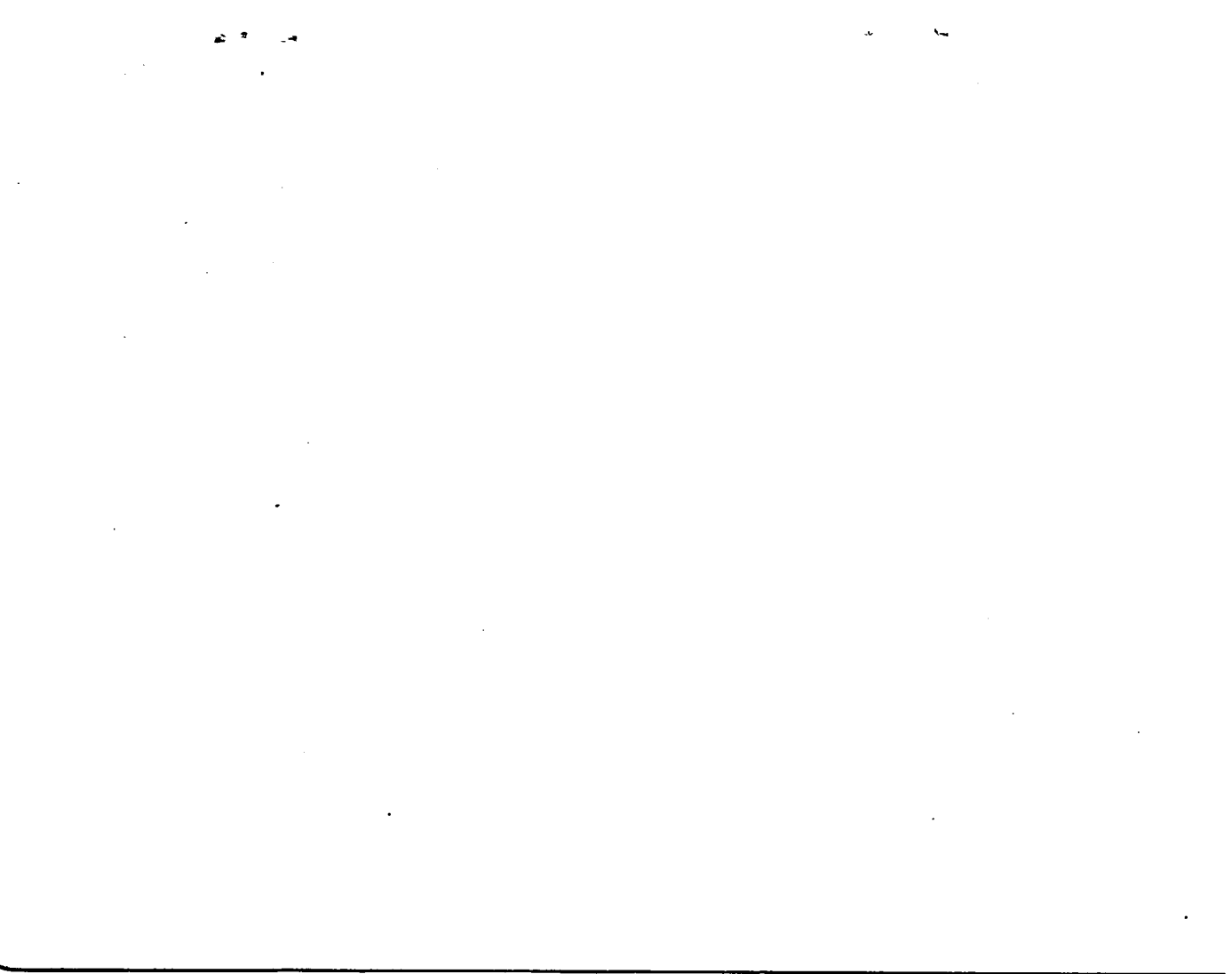
(Signature) Robert H. Wright-M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Hailey, Ida

Filed Jan 3 1924 Robert H. Wright
Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 57
City of Hailey Primary Registration District No. 2022
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis DarcyFile No. 43977
Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

Nov. 30 1923
(Month) (Day) (Year)

7. AGE

StillbirthIF LESS than 1 day
how many ✓ hrs.
or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hailey, Ida.

10. NAME OF FATHER

James L. Darcy

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mavis Arnold

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James L. Darcy
(Address) Hailey, Ida.

15.

Filed

\$-5

19

74R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Wright

(Month)

30
(Day)1923
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Robert H. Wright M. D.12-1-1923(Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey Ida.Dec 3 1923

20. UNDERTAKER

ADDRESS

J. H. Harris

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

534-115-002-132

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine **RECEIVED** **JAN 11 1927** **BUREAU OF VITAL STATISTICS**
City of Barre **CERTIFICATE OF BIRTH**
No. 57 State File No. 117563
Hospital _____ Primary Registration District No. 2075 Local Registrar's No. 90
FULL NAME OF CHILD Babies Eldredge

FULL NAME OF CHILD Walter Oldredge

(Certificate of no value without full name of child)

Sex of 2 Child <i>Males</i>	Twin <i>Triplet</i> and { Number in order of birth } (To be answered only in event of plural births)	Legitimate? <i>Yes</i>	Date of birth <i>10 15 1923</i> (Month) (Day) (Year)
-----------------------------	---	------------------------	---

What bactericidal solution was used in eyes?.....none

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 0

FULL NAME FATHER
Oliver O Eldredge

RESIDENCE Carey

COLOR Light AGE AT LAST BIRTHDAY 28
(Years)

BIRTHPLACE Deho

OCCUPATION Student

FULL MAIDEN NAME **MOTHER** *Virginia Robinson*

RESIDENCE J Carey

COLOR *W. h. l.* AGE AT LAST BIRTHDAY 19
(Years)

BIRTHPLACE Alaska

OCCUPATION Handwritten

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was ^{born alive} ~~Stillborn~~ at 210 P. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

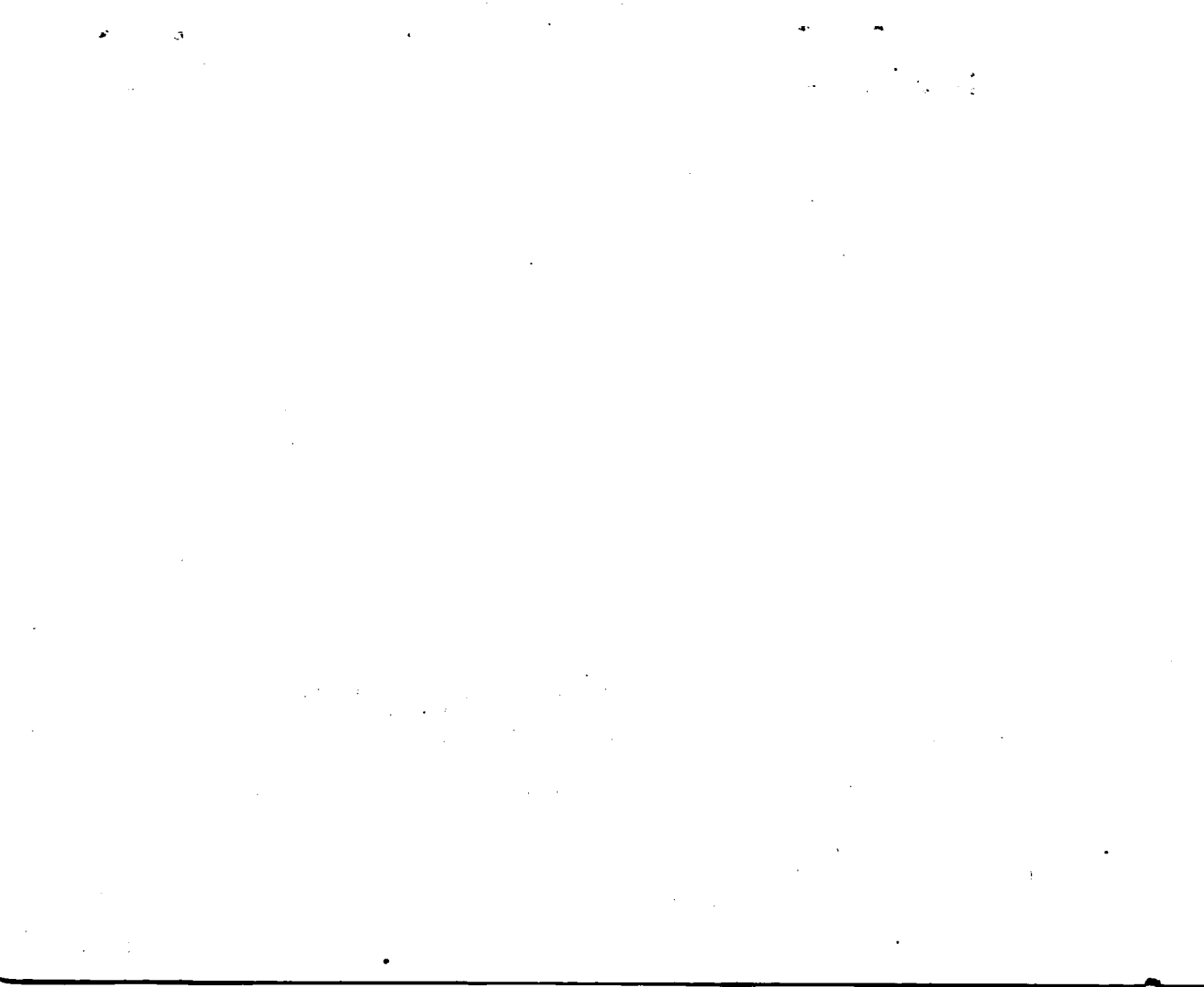
his child, who was { Born alive } at 2:10 P. M.
 { Stillborn }
 (Signature) Houston E. Snyder
 Physician
 (Physician or midwife)

Address Barry, Pa.

Filed 1-14 1924 Robert H. Wright

Registrar.

Registrar



CERTIFICATE OF DEATH

43974

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blairstown
City of Carey

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JAN 15 1924BUREAU OF VITAL
STATISTICS

2. FULL NAME

Registration District No. 57

Primary Registration District No. 2075

St.)

File No.

Registered No. 56

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

10 15 1923
(Month) (Day) (Year)

7. AGE

Still Born

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Still Born

9. BIRTHPLACE

(State or Country)

Carey Idaho

10. NAME OF FATHER

Othmer Q Eldredge

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Virginia Alkinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H E Snyder

(Address)

Carey, Ida

15.

Filed 1-14 1924

P. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 15 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-15 1923 to 10-15 1923

that I last saw h. alive on Still Born 19

and that death occurred on the date stated above, at Carey M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. ds.
Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Thornton E Snyder M. D.

12-16 1923 (Address) Carey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Carey, Ida

DATE OF BURIAL

10-16 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

534-115-007-132
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED
JAN 10 1924
BUREAU OF
STATISTICS

CERTIFICATE OF BIRTH

County of Blaine

City of Carey

No. _____ St. _____

Hospital _____

Registration District No. 57 File No. 117564

Primary Registration District No. 2075 Registered No. 91

FULL NAME OF CHILD

Baby Eldredge

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <u>Triplet</u> and <u>other</u> <u>or other</u> (To be answered only in event of plural births)	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>10</u> <u>15</u> <u>1923</u> (Month) (Day) (Year)
--------------------------	---	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Oliver O. Eldredge
RESIDENCE Carey, Ida
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Virginia Atkinson
RESIDENCE Carey, Ida
COLOR White AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Steelborn at 2 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

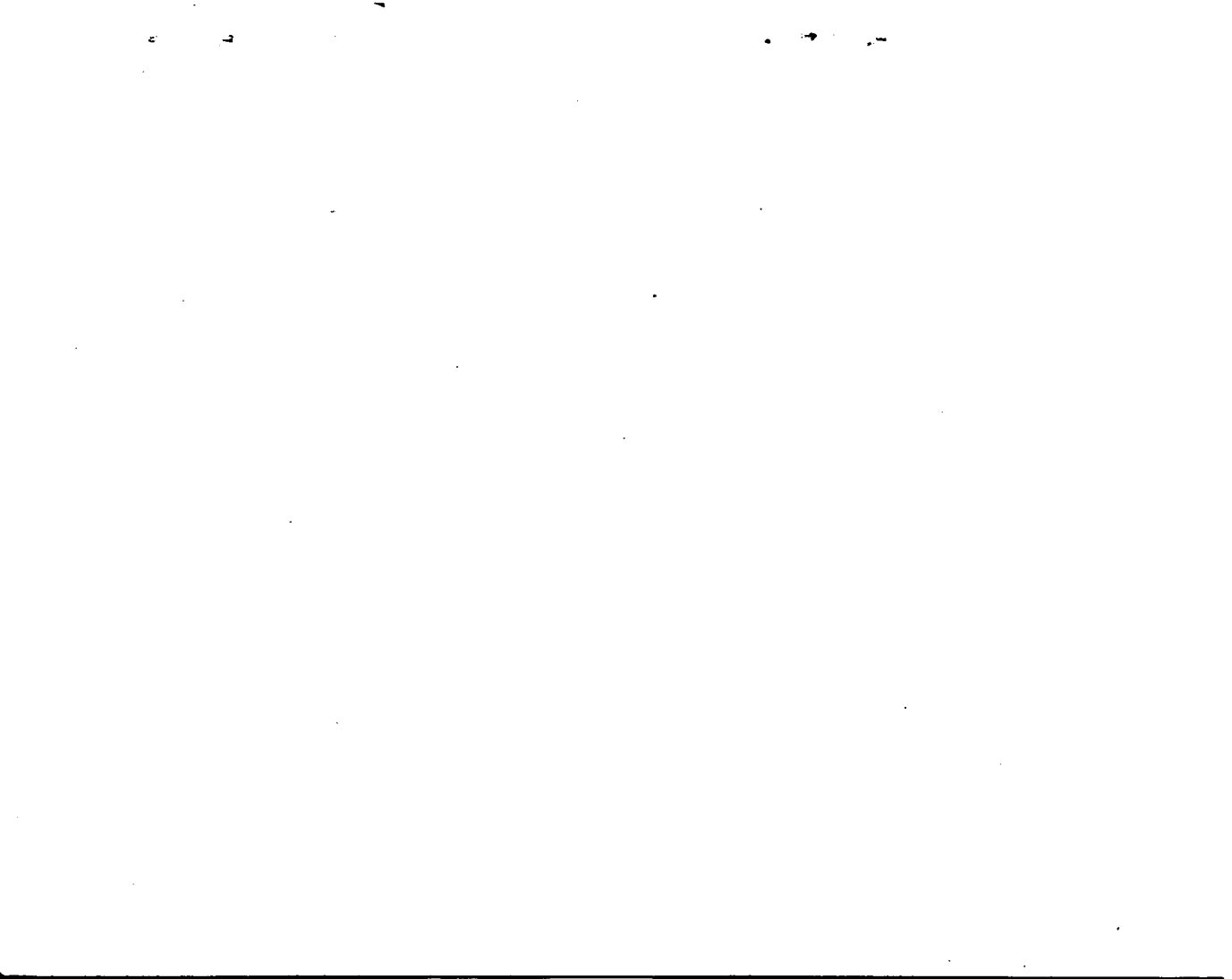
(Signature) Houston E. Snyder

(Physician or midwife)

Give names added from a supplemental report.
_____, 19_____

Registrar.

Address Carey, Ida
Filed 1-14-1924 Phet H. Wright
Registrar.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Blaine
City of Carey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Eldredge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

10 15 1923
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Carey, Ida

10. NAME OF FATHER

Oliver E. Eldredge

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Virginia Atkinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. E. Snyder
(Address) Carey, Ida

15.

Filed 1-14 1924 P. H. Wright
Local Registrar

CERTIFICATE OF DEATH

Registration District No.

57

Registration District No.

2025

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

43975

Registered No.

57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 15 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
10-15 1923 to 10-15 1923

that I last saw him _____ alive on _____ 19____.

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn - Don't Know

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Harveston E. Snyder12-16-23 (Address) Carey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carey Ida10/16/1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

693-215.034-945

PLACE OF BIRTH

STATE OF IDAHO

Form V. S. No. 11-C--25m-7-21-19

BUREAU OF VITAL STATISTICS

County of Minidoka

RECEIVED JAN 8 1924 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 117608

City of MinidokaRegistration District No. 19

File No. _____

No. _____ St. _____

Primary Registration District No. 2013 Registered No. _____

Hospital _____

FULL NAME OF CHILD

(unnamed)

Wilkinson

Sex of Child

FemaleTwin
Triplet
or other?

{ and }

Number
in order
of birth

(To be answered only in event of plural births)

Legiti
mate?yesDate of
BirthDec. 15
(Month) (Day)1923
(Year)FULL
NAME

FATHER

Thomas L. WilkinsonFULL
MAIDEN
NAME

MOTHER

Grace Randall

RESIDENCE

Minidoka, Idaho

RESIDENCE

Minidoka, Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY45
(Years)

COLOR

whiteAGE AT LAST
BIRTHDAY42
(Years)

BIRTHPLACE

Oregon

BIRTHPLACE

Oregon

OCCUPATION

Round House Foreman

OCCUPATION

Housewife

Number of child of this mother, including present birth _____ Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.stillborn
(Born alive or stillborn)at 2:15 A. M.

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Leland Frasier
Physician

(Physician or midwife)

Given names added from a supplemental report.

19 _____

Address

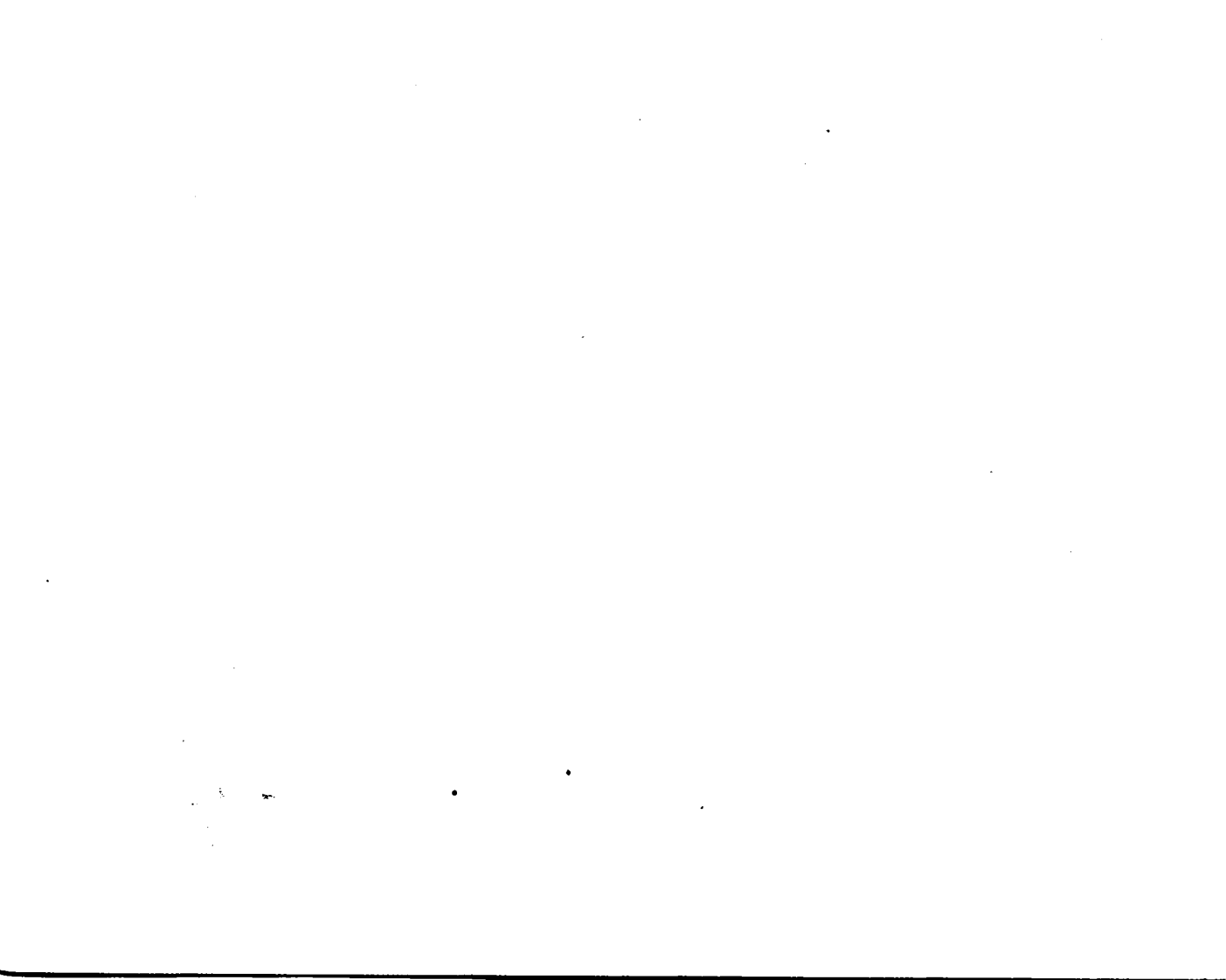
Rupert, Idaho

Filed

1/5 1924CP Groves
Registrar

Registrar

slap



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

213-2091014-897
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon
City of Wilder
No. _____ St. _____
Hospital Home Primary Registration District No. 2007 Registered No. 94
FULL NAME OF CHILD Erma Pearl Sale
(Certificate of no value without full name of child.)

Sex of Child 7 Twin Triplet or other? _____ and _____ Number in order of birth _____ Legitimate? yes Date of birth Nov 9 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME <u>F. M. Sale</u>	FATHER	FULL MAIDEN NAME <u>Hazel Heggens</u>	MOTHER
RESIDENCE <u>Wilder Ida</u>		RESIDENCE <u>Wilder Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>24</u> (years)
BIRTHPLACE <u>Kansas</u>		BIRTHPLACE <u>Ochrosha</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at Wilder M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

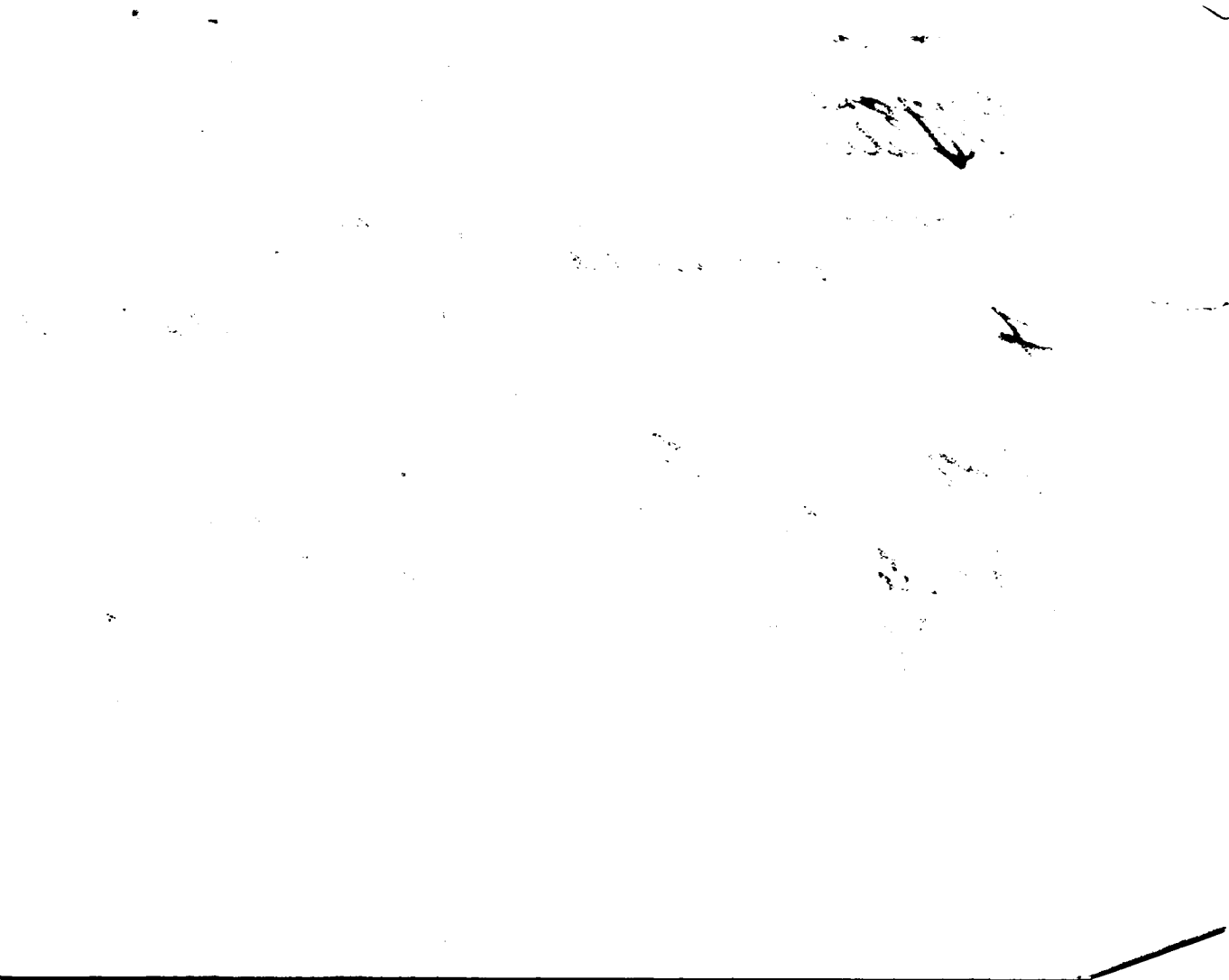
Give names added from a supplemental report.

(Signature) A. J. Bond M.D.
Physician
(Physician or midwife)

Address Wilder Ida

Filed 1 1924 Lulu Waldorf
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of CanyonCity of Wilder

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carm Pearl Sale

CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 2005STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 43766Local Registrar's No. 88

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

(Write the word)

4. DATE OF BIRTH

Nov 9 1923
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day how many
— hrs. or
— min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J M Sale

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Hazel Higgins

13. BIRTHPLACE OF MOTHER

(State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F M Sale(Address) Wilder Ida

15.

Filed Nov. 10 - 1923 John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 9 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1923 to 19that I last saw him alive on 19
and that death occurred on the date stated above, at 2:30 P.

The CAUSE OF DEATH* was as follows:

Stillborn(Duration) — yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) A B Bouch M. D.19. (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place — yrs. — mos. — days. In the State — yrs. — mos. — ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Wilder Cem

DATE OF BURIAL

11-10 1923

20. UNDERTAKER

E. J. Beckham Caldwell

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED

JAN 7 1924

CERTIFICATE OF BIRTH

S117723

County of CanyonCity of Idaho FallsNo. 308, 20th and St.

Hospital _____

FULL NAME OF CHILD

Primary Registration District No. 1006

File No. _____

Registered No. _____

Sex of Child M {Twin
Triplet
or other? } and {Number
in order
of birth } 5 Legiti-
(To be answered only in event of plural births) mate? yes Date of
Birth 11-16-23
(Month) (Day) (Year)

FULL NAME <u>FATHER</u> <u>Walter L. Farris</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Flora Hall</u>
RESIDENCE <u>Idaho Falls</u>	RESIDENCE <u>Idaho Falls</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Mo.</u>	BIRTHPLACE <u>Mich.</u>
OCCUPATION <u>R.R. man</u>	OCCUPATION <u>House wife</u>

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

Given names added from a supplemental report.

19

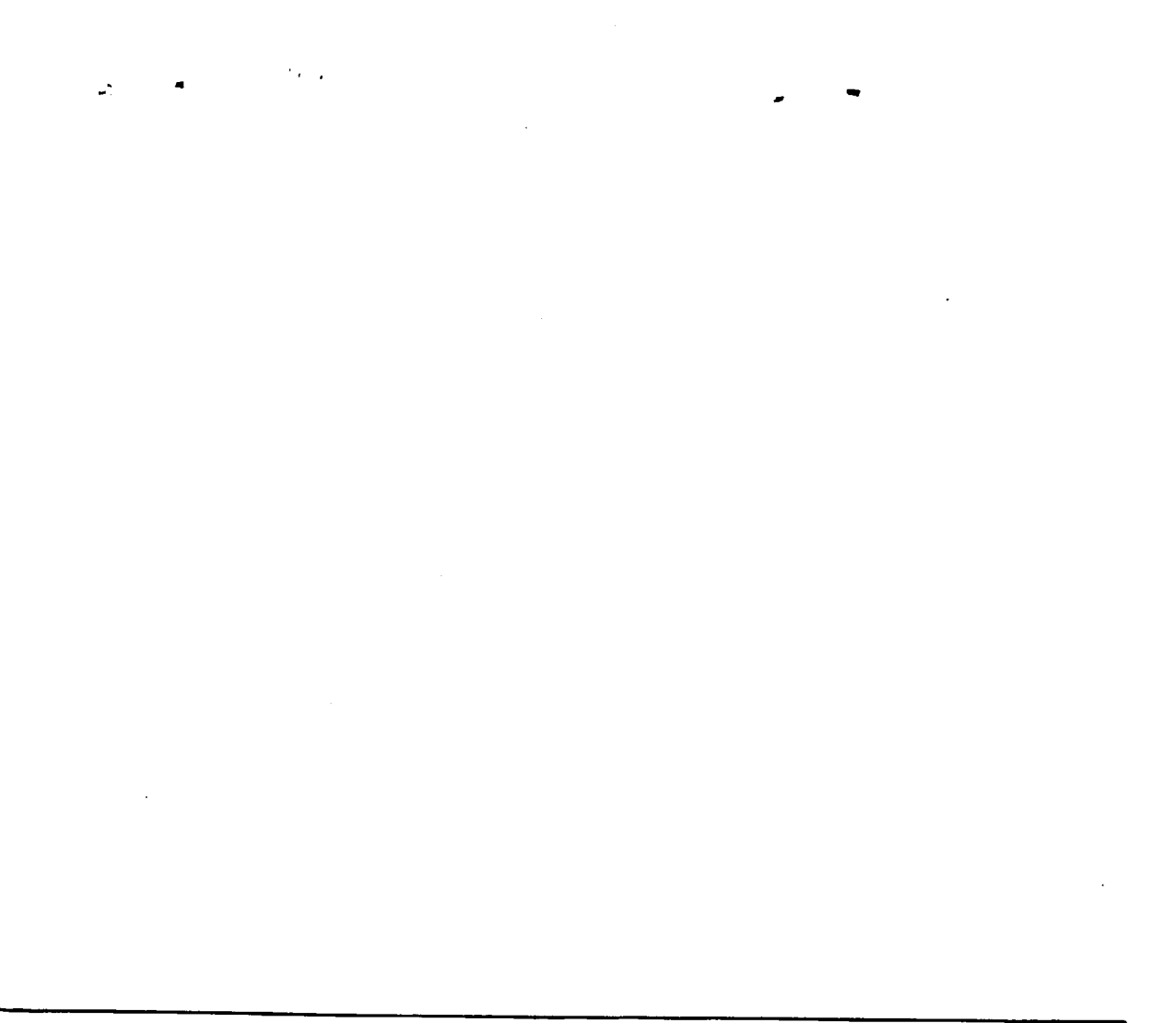
still born at _____ M.
(Born alive or stillborn)
(Signature) Dr. C. Robinson
Physician
(Physician or midwife)

Address

Filed

1317 4th St. Nampa
Jan. 4 1924 Pearle Dodds
Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of Nampa

RECEIVED
DEC 8 1923
BUREAU OF
STATE

Registration District No. _____

Primary Registration District No. _____

St. _____

File No. 43758

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

(Write the word.)

6. DATE OF BIRTH

11 16 1923
(Month) (Day) (Year)

7. AGE

✓ Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. L. Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Florence Hill

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

St. L. Harris

(Address)

Nampa, Ida

15.

Filed Dec 4 1923

Pearl Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still born

11 16 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____ to _____ 19____

that I last saw h. _____ alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Strangulation of Cord

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Robinson M. D.

11-16-1923 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Robinson

11-17-1923

20. UNDERTAKER

ADDRESS

H. C. Robinson

Nampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

533-027-017-619
PLACE OF BIRTH

County of Clark
City of Small PO

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD _____

RECEIVED STATE OF IDAHO
BUREAU OF VITAL STATISTICS
DEC 20 1923
BUREAU OF VITAL
STATISTICS

Registration District No. 125

Primary Registration District No. 2203

Form V. S. No. 11-C-25m-7-21-19

S
117826
File No. _____

Sex of Child	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legitimate?	Date of Birth 11 27 1923 (Month) (Day) (Year)
--------------	--	-----	---	-------------	---

FULL NAME <u>Philip D. Ellis</u>	FATHER
RESIDENCE <u>Small</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Small</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Hazel Warming</u>	MOTHER
RESIDENCE <u>Small</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Plains City Utah</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth _____ Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born Dead at 5- a.m.
on the date above stated. (Born alive or stillborn)

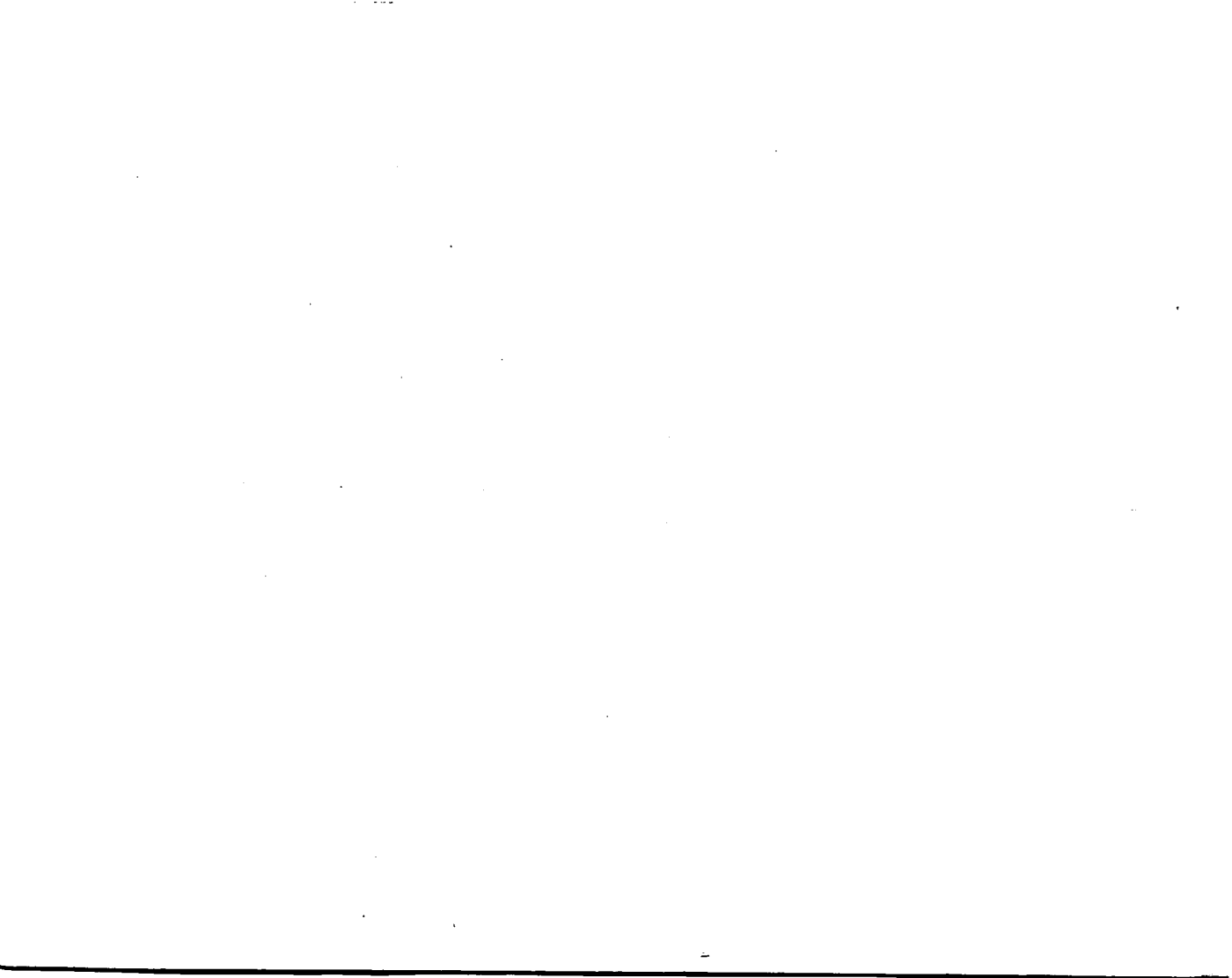
*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature) A. D. Tucker
Emergency midwife
(Physician or midwife)

Address _____
Filed Nov 30 1923
Registrar W E Jones M D

Registrar



537-127-07-619

PLACE OF BIRTH

County of ClarkCity of Small PO

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>11 27</u> (Month) (Day) <u>1923</u> (Year)
--------------------------	---	--------------------------------------	----------------------------	---

FULL NAME <u>Philip D. Ellis</u>	FATHER
RESIDENCE <u>Small</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Small</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Hazel Warming</u>	MOTHER
RESIDENCE <u>Small</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Plains City Utah</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth	Number of children of this mother now living, including present birth
---	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born 5 at 5 a.m.
on the date above stated. (Born born stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19.

Registrar

(Signature)

R.D. Tucker
Emergency midwife
(Physician or midwife)

Address

Spencer Ida
Filed Nov 30 1923 W.E. Jones M.D.

Registrar

RECEIVED

DEC 20 1923

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
BUREAU OF CERTIFICATE OF BIRTH
STATISTICS

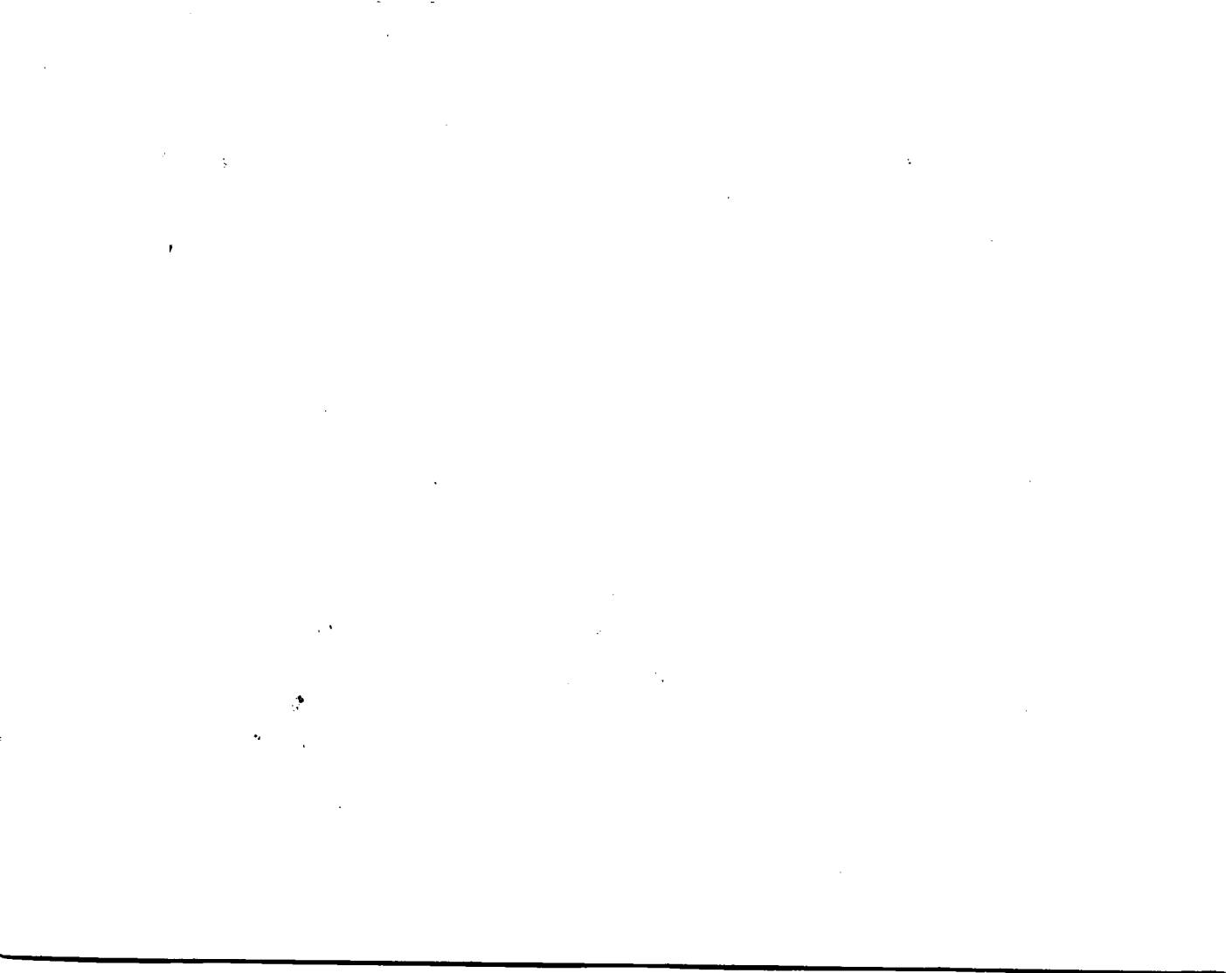
Registration District No. 125Primary Registration District No. 2203

Form V. S. No. 11-C-25m-7-21-19

S

File No. 117827

Registered No. _____



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

363-121-021-386
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin

City of Tairview, Idaho

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 27 State File No. 117882

Hospital _____ Primary Registration District No. 2119 Local Registrar's No. 240

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	<u>Twin</u> <u>Triplet</u> <u>or other?</u> (To be answered only in event of plural births)	and	<u>Number</u> <u>in order</u> <u>of birth</u> (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>Nov. 21, 1923</u> (Month) (Day) (Year)
--------------------------	--	-----	--	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Lorin Cole

MOTHER
FULL MAIDEN NAME Vera Margaret Thompson

RESIDENCE Tairview, Idaho.

RESIDENCE Tairview, Idaho.

COLOR White AGE AT LAST BIRTHDAY 28
(Years)

COLOR White AGE AT LAST BIRTHDAY 20
(Years)

BIRTHPLACE Tairview, Idaho.

BIRTHPLACE Tairview, Idaho.

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive 3.30 A. M.
on the date above stated. Stillborn at _____

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____

Physician

(Physician or midwife)

Give names added from a supplemental report.

Address Preston, Idaho.

Filed Dec 5 1923 Mrs. H. L. Lippert
Registrar.

Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

288714

Registration District No. _____ State File No. 711882

Primary Registration District No. _____ Local Registration No. _____

(Certificate of no value without full name of child)

.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

SECRET

7-17-1964

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
DEC 20 1923
BUREAU
STATE

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Franklin
City of Fairview
Registration District No. 27
Primary Registration District No. 2119
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44071
Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)
6. DATE OF BIRTH November 21, 1923
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many _____ hrs. of remanure

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Fairview, Idaho.

10. NAME OF FATHER Lorin A. Cole.

11. BIRTHPLACE OF FATHER
(State or Country) Fairview, Idaho.

12. MAIDEN NAME OF MOTHER Vern Marget Thompson.

13. BIRTHPLACE OF MOTHER
(State or Country) Fairview, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorin A. Cole
(Address) Fairview, Idaho.

15. Dec. 5 1923
Filed 19 Mrs. H. L. Lupton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November 21, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Nov. 21, 1923 to Nov. 21, 1923 that I last saw him alive on Nov. 21, 1923 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Death from strangulation in birth canal.

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) G. W. States M. D.

Nov. 21, 1923 (Address) Reston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Life mos. _____ days. In the State Life mos. _____ days.

Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Fairview Cemetery DATE OF BURIAL Nov. 22, 1923.

20. UNDERTAKER Wm. C. Erickson, ADDRESS Reston, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

916-223-021-269
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin

City of Preston

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 27 State File No. 117903

Hospital _____ Primary Registration District No. 8119 Local Registrar's No. 255

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	<u>Twin</u> and { Number in order of birth <u>2</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 23</u> <u>1923</u> (Month) (Day) (Year)
--------------------------	---	---	------------------------	---

What bactericidal solution was used in eyes? 20 % Ag.

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FULL NAME <u>Henry Rawlings</u>	FATHER
RESIDENCE <u>Preston, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farming</u>	

FULL MAIDEN NAME <u>Treasa Sorensen</u>	MOTHER
RESIDENCE <u>Preston, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>New Jersey</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 2:40 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

G. R. Culler
Physician

(Physician or midwife)

Address Preston, Idaho

Filed Jan 2 1924

Registrar.

Registrar.

name was added to wrong twin on 11/6/79. corrected mistake 3/28/11 ly

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Franklin Registration District No. 27
 City of Preston Primary Registration District No. 2119
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 44065
 Registered No. 423

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

Dec. 23 1923
 (Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
 how many ? hrs.
 or 0 min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry Rawlings

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Irena Sorensen

13. BIRTHPLACE OF MOTHER

(State or Country)

New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Jan 3 1924 Mrs. Stapp
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 23 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1923, to Dec 23 1923
 that I last saw h. alive on 1923
 and that death occurred on the date stated above, at 2:45 P.M.
 The CAUSE OF DEATH* was as follows:
Stillborn

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. R. Outley M. D.

12 1923 (Address) City

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston, Ida. Dec. 24 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

492-103-024-133

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of GoodingCity of NagermanRegistration District No. 21File No. 117996

No. _____ St. _____

Primary Registration District No. _____ Registered No. _____

Hospital _____

FULL NAME OF CHILD

Jeff Mikesell

Sex of Child

maleTwin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?geoDate of
BirthDec 319 23

(To be answered only in event of plural births)

(Month) (Day) (Year)

FULL
NAMEJeff Mikesell

FATHER

RESIDENCE

Nagerman

COLOR

WhiteAGE AT LAST
BIRTHDAY3.5-

(Years)

BIRTHPLACE

Utah

OCCUPATION

FarmerFULL
MAIDEN
NAMEFlorence Allen

MOTHER

RESIDENCE

Nagerman

COLOR

WhiteAGE AT LAST
BIRTHDAY22

(Years)

BIRTHPLACE

Utah

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born, at 8 PM M.
on the date above stated. (Born alive or stillborn)*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

I. H. Greene

(Physician or midwife)

Physician

Given names added from a supplemental report.

19

Address

Nagerman

Filed

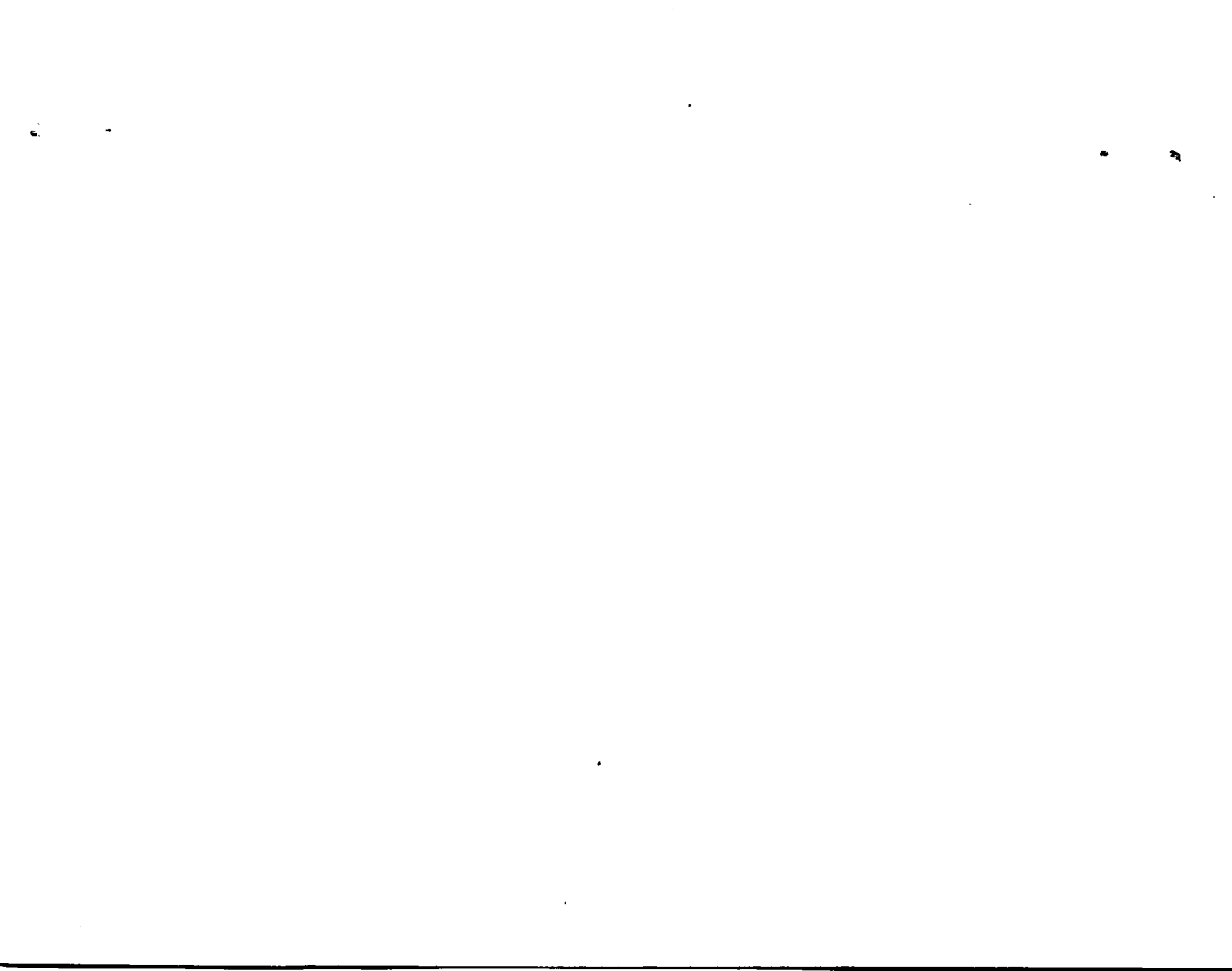
Dec 5 1923I. H. Greene

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44077
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Gooding
City of Hagerman
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Jeff Mikesell
Registration District No. 2
Primary Registration District No.
(No. St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH Nov 19 1923
(Month) (Day) (Year)
7. AGE Still born
IF LESS than 1 day how many hrs. or mos. ds. min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Hagerman Ida
(State or Country)

10. NAME OF FATHER Jeff Mikesell

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Florence Allen

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jeff Mikesell

(Address) Hagerman

15.

Filed Dec 24 1923 R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 18 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1923 to 1923
that I last saw him alive on 1923
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

No life
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hagerman Dec 19 1923
20. UNDERTAKER ADDRESS
None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

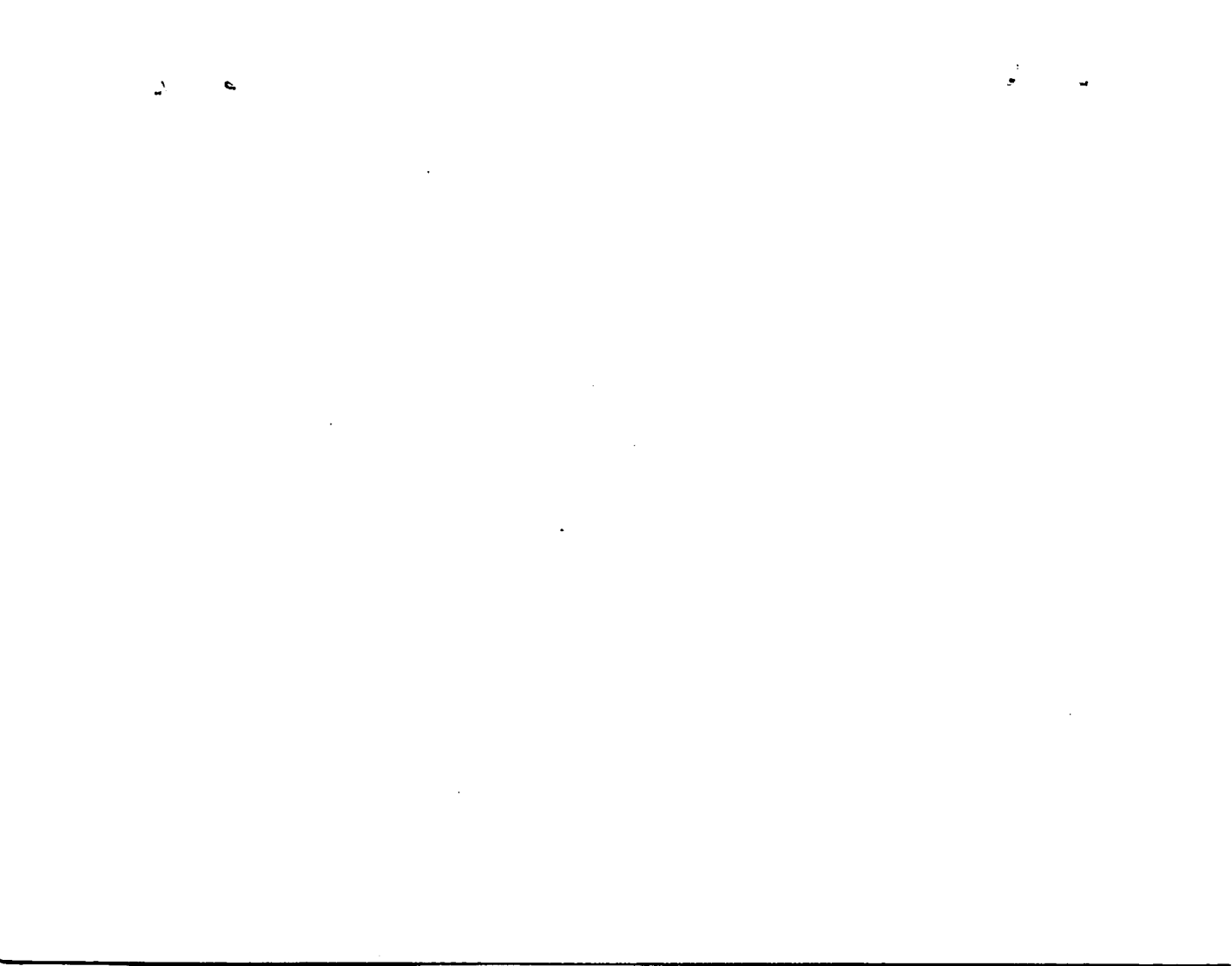
STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

795-119.024-399

Form V. S. No. 11-C--25m-7-21-19

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Gooding</u>		BUREAU OF VITAL STATISTICS	
City of <u>Hagerman</u>		CERTIFICATE OF BIRTH	
Registration District No. <u>21</u>		File No. <u>117997</u>	
No. _____ St.		Primary Registration District No. _____ Registered No. _____	
Hospital _____		FULL NAME OF CHILD <u>Theodore Green</u>	
Sex of Child <u>male</u>	Twins or other? <u>and</u>	Number in order of birth _____	Legitimate? <u>yes</u>
(To be answered only in event of plural births)		Date of Birth <u>Nov 19</u> 19 <u>23</u>	(Month) (Day) (Year)
FULL NAME <u>John W. Green</u>	FATHER	FULL MAIDEN NAME <u>Annie V. Crist</u>	MOTHER
RESIDENCE <u>Hagerman</u>		RESIDENCE <u>Hagerman</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	
Number of child of this mother, including present birth <u>4</u>		Number of children of this mother now living, including present birth _____	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> , at <u>530 a</u> M. on the date above stated.		(Born alive or stillborn)	
*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.		(Signature) <u>R. H. Greene</u>	
Given names added from a supplemental report. _____ 19 _____		<u>Physician</u> (Physician or midwife)	
Address <u>Hagerman</u>		Filed <u>Nov 24 1923</u>	
Registrar _____		Registrar <u>R. H. Greene</u>	



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 11075
Registered No.

1. PLACE OF DEATH. Registration District No. 21
County of Gooding Primary Registration District No.
City of Hagerman (No. St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Theodore Green

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
6. DATE OF BIRTH Jan 19 1923 (Month) (Day) (Year)
7. AGE Still born IF LESS than 1 day how many hrs. or mos. ds. min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Hagerman Ida

10. NAME OF FATHER John W. Green

11. BIRTHPLACE OF FATHER Idaho (State or Country)

12. MAIDEN NAME OF MOTHER Annie Crist

13. BIRTHPLACE OF MOTHER Ida (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. H. Green
(Address) Hagerman

15. Filed Dec 10 1923 R. H. Green Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 19 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from during delivery 191 that I last saw h alive on 191 and that death occurred on the date stated above, at Stillborn M.

The CAUSE OF DEATH* was as follows:

Infant
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. H. Green M. D.
Dec 10 1923 (Address) Hagerman

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hagerman Cemetery Nov 20 1923

20. UNDERTAKER ADDRESS none

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 01-10-2001 BY 60322 UCBAW/STP/STP

PLACE OF BIRTH

433-117025-363

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of.....

City of.....

No.....St.

BUREAU
ST

Registration District No..... State File No.....

118028

Hospital.....

Primary Registration District No..... Local Registrar's No.....

FULL NAME OF CHILD

(died) Clark M^c Coy

(Certificate of no value without full name of child.)

Sex of Child	Male	Twin Triplet or other?		and	Number in order of birth	Legitimate?	Yes	Date of birth	Nov 17 -	1923
		(To be answered only in event of plural births)						(Month)	(Day)	(Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth.....5..... Number of child of this mother now living, including present birth.....4.....

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL NAME	RESIDENCE
Clark M ^c Coy	Canfield P.O.	Edna Jane Cochran	White Canfield P.O.
COLOR	AGE AT LAST BIRTHDAY	COLOR	AGE AT LAST BIRTHDAY
white	45 (Years)	white	37 (Years)
BIRTHPLACE	OCCUPATION	BIRTHPLACE	OCCUPATION
Cal.	Rancher	Washington	Post mistress

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2 - P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W.A. Foskett M.D.

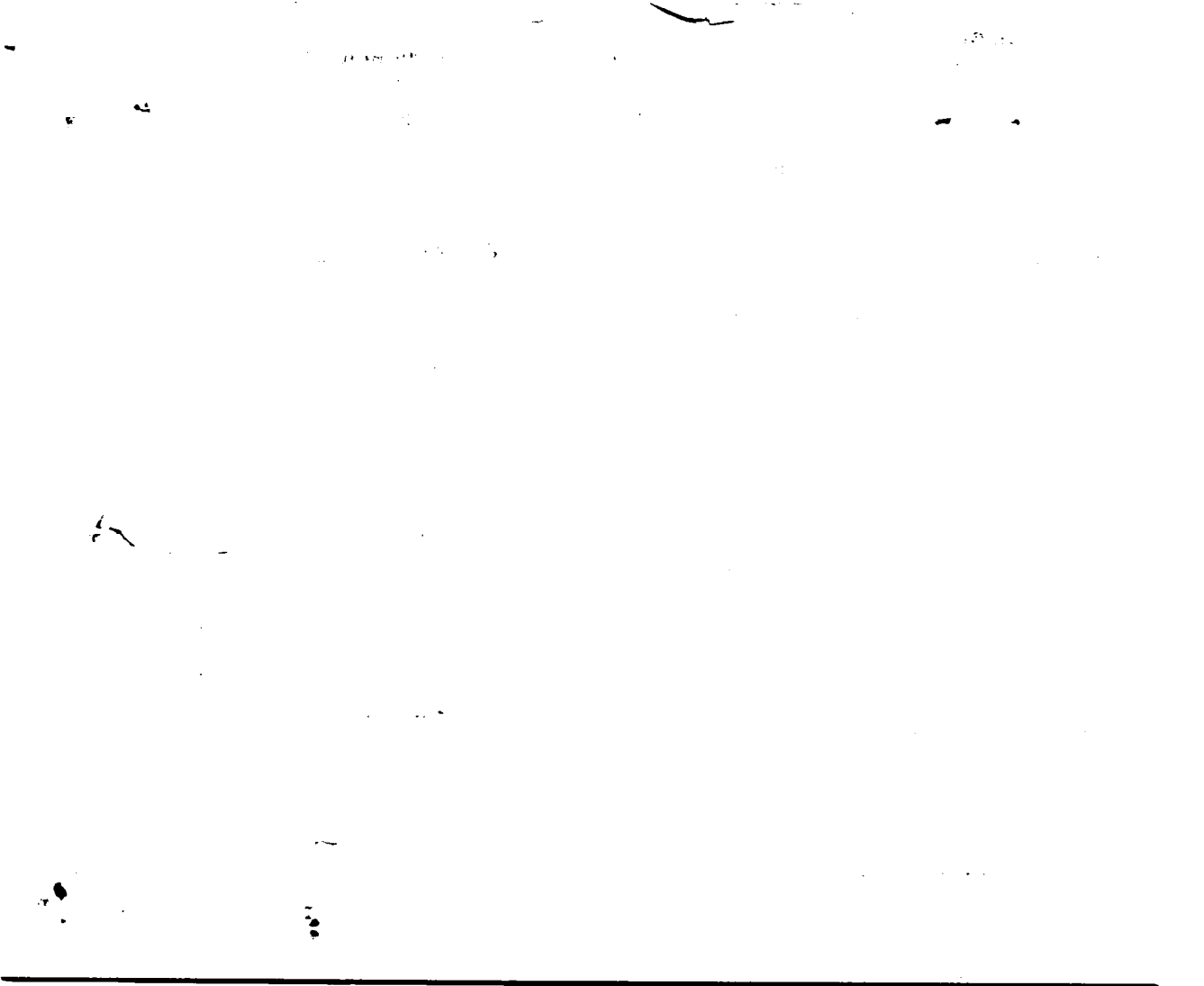
(Physician or midwife)

Give names added from a supplemental report.

Address White Bird - IdaFiled Dec 10 1923 W.A. Foskett

Registrar.

Registrar.



STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho JAN 21 1924 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

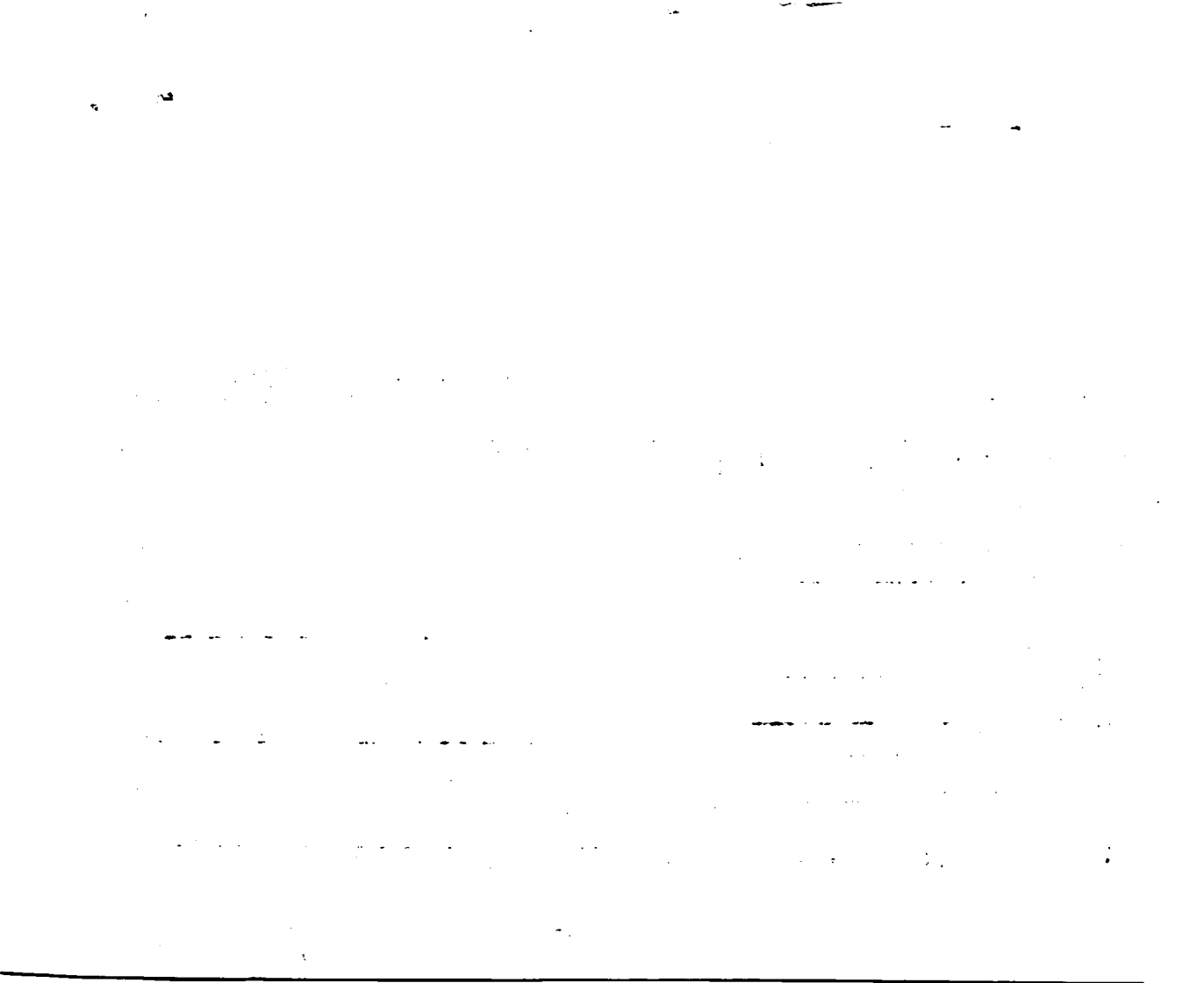
Place of Birth (CITY White Bird FILE NO. 118028
 (ST. _____ DATE OF BIRTH Nov. 17, 1923
 (COUNTY Idaho SEX OF CHILD Male
 FATHER Albert C. McCoy MOTHER Edna J. Cochran
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

The child was dead born- Clark McCoy would
have been part of the name
A. C. McCoy.

Signature of Father or Mother.

ED
1924



FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

1924 CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41089

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

male

white

child
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)17
(Day)1923
(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

white Bird

10. NAME OF FATHER

Clark M. Coy

11. BIRTHPLACE OF FATHER

(State or Country)

California

12. MAIDEN NAME OF MOTHER

Edna Jane Cochran

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clark M. Coy

(Address)

Canfield 2 dg

15.

Filed.....19.....

W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

17

1923

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Sullivan

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grangerville

Nov 20, 1923

20. UNDERTAKER

ADDRESS

Hancock

Grangerville

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

291-207026-693
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Jefferson

City of Rigby

Registration District No. 98

File No. 118059

No. _____ St. _____

Primary Registration District No. 2176 Registered No. 242

Hospital _____

FULL NAME OF CHILD Stillborn

Sex of Child Female Twin Triplet or other? ✓ and { Number in order of birth ✓ Legitimate? yes Date of Birth July 3 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER
FULL NAME N. M. Bromwell
RESIDENCE Rigby
COLOR W AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Rhodelia Williams
RESIDENCE Rigby
COLOR W AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. M. Palmer

(Physician or midwife)

Given names added from a supplemental report.

Address Rigby

Filed 12-10-23

Registrar.

Registrar.

[illegible]

Abstract

1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Arar and Collins (1971) using a Shimadzu 1010 spectrophotometer. The concentration of chlorophylls was expressed as $\mu\text{g mL}^{-1}$ of the sample.

•

• • • • •

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho JAN 30 1924 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

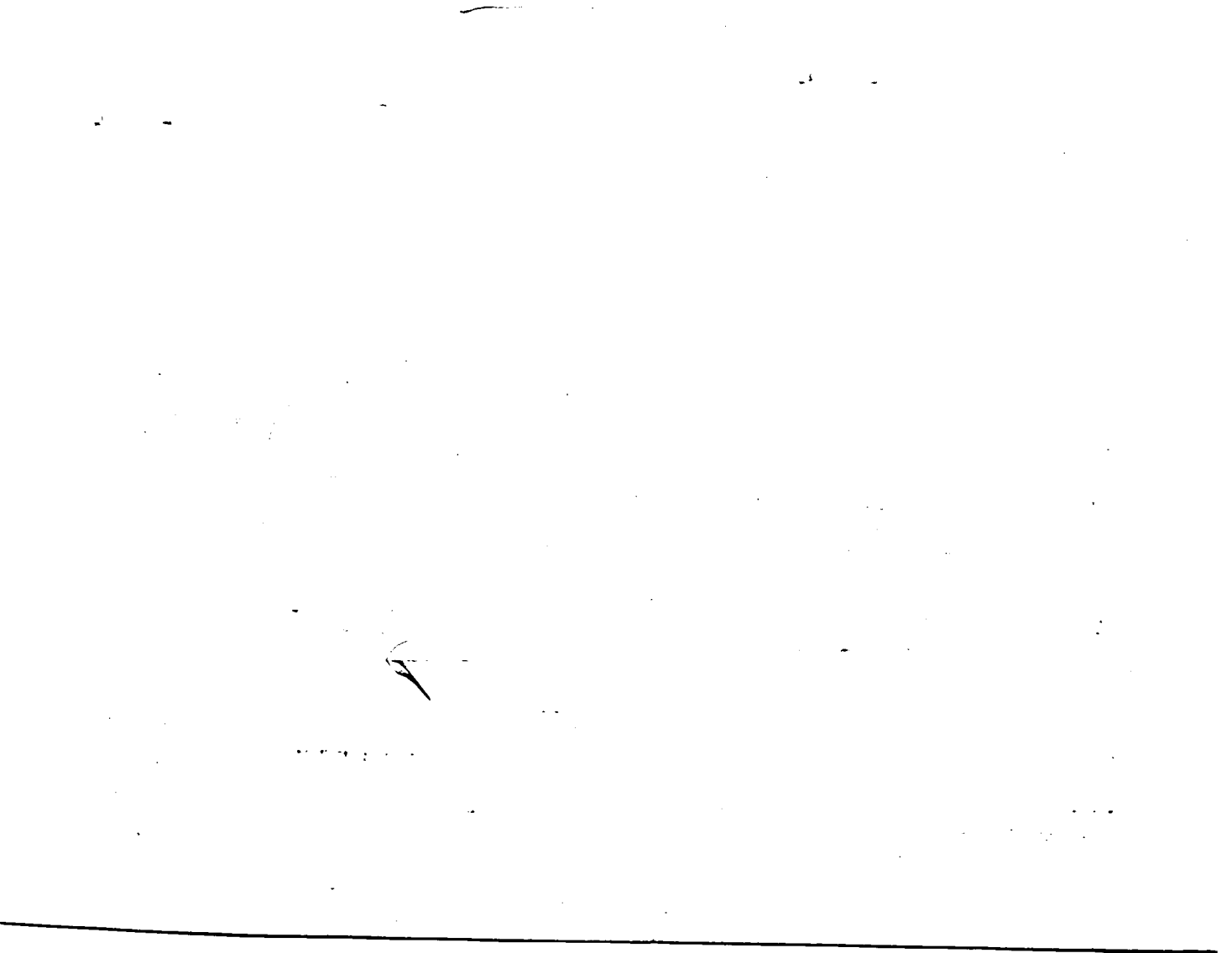
* * * * *

Place of Birth (CITY Rigby FILE NO. 118059
(ST. _____ DATE OF BIRTH 3 July
(COUNTY Jefferson SEX OF CHILD Female
FATHER H. M. Bramwell MOTHER Shelia Williams
(Maiden Name)

I HEREBY CERTIFY that the child herein described has ~~been~~ not beennamed she was a still born babeH. M. Bramwell

Signature of Father or Mother

RECEIVED
JAN 30 1924
VITAL
STATISTICS



FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson Registration District No. 9-8
 City of Rigby Primary Registration District No. 2176
 No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX J 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
 (Write the word.)

6. DATE OF BIRTH

July 3 1923
 (Month) (Day) (Year)

7. AGE

stillborn
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. M. Bramwell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Rhodelia Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. M. Bramwell

(Address)

Rigby, Idaho

15.

Filed 12-10 1923Ray H. Fisher

Local Registrar

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 41099Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7-3 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....
 that I last saw h..... alive on 19.....
 and that death occurred on the date stated above, at.....M.
 The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) a. m. Palmer M. D.

7-4 1923 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rigby

DATE OF BURIAL

7-4 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

236-1151026-893
PLACE OF BIRTH

Form V. S. No. 11—20m-V-28-18

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of JeffersonCity of PayleyRegistration District No. 98File No. 118060

No. _____ St. _____

Primary Registration District No. 2176Registered No. 249

Hospital _____

FULL NAME OF CHILD _____

Sex of
Childm.Twin
Triplet
or other? ✓
(To be answered only in event of plural births)and { Number
of birth ✓Legiti-
mate? yesDate of
BirthAug 151923

(Month) (Day) (Year)

FULL
NAMEFATHER
C. F. StonehockerFULL
MAIDEN
NAMEMOTHER
Frances Hill

RESIDENCE

Payley

RESIDENCE

Payley

COLOR

wAGE AT LAST
BIRTHDAY23

(Years)

COLOR

wAGE AT LAST
BIRTHDAY19

(Years)

BIRTHPLACE

Neb.

BIRTHPLACE

Idaho

OCCUPATION

Mgr. Gasoline Station

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

Given names added from a supplemental report.

19

Address

(Physician or midwife)

Filed

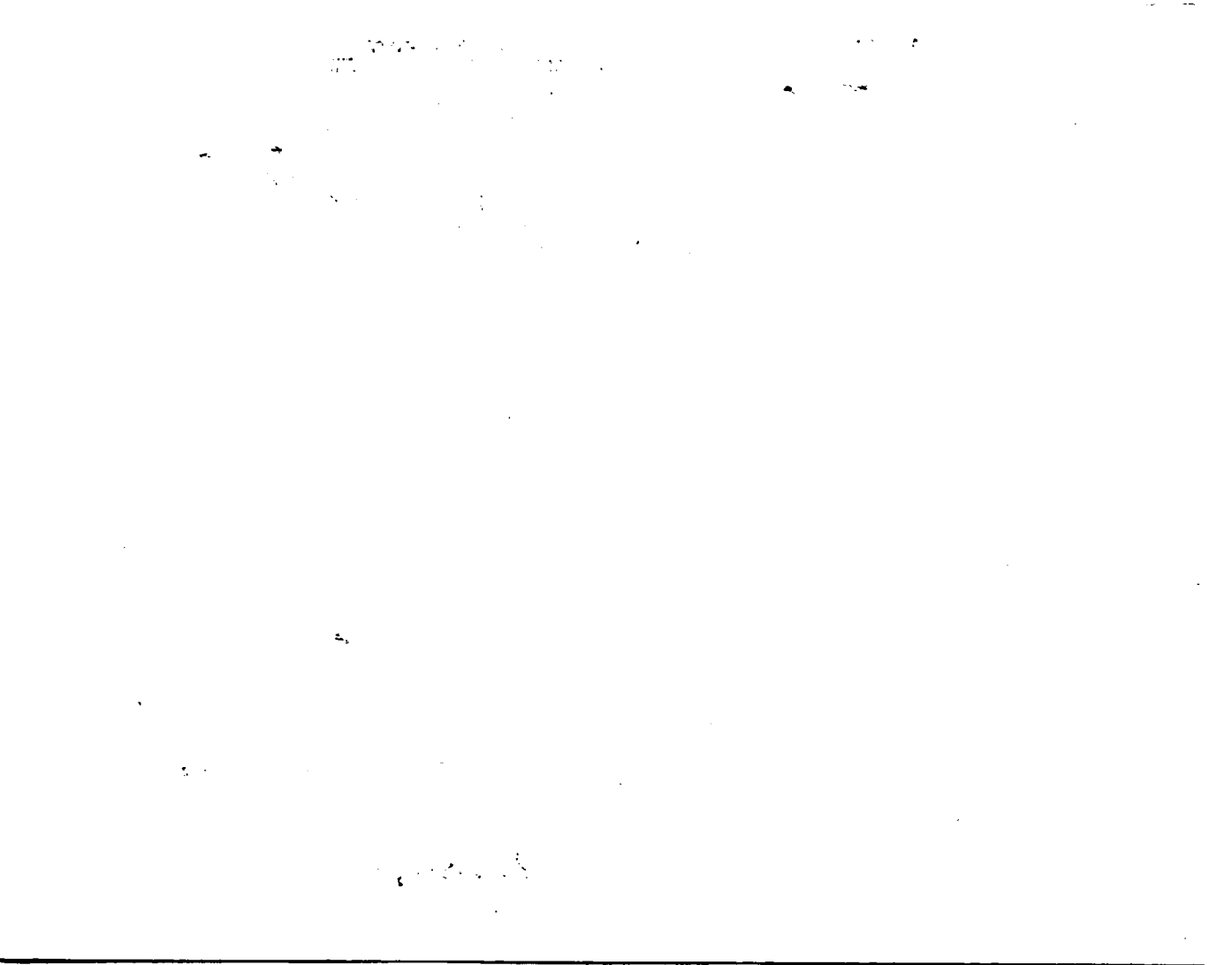
12-10

19

23Payley

Registrar.

Registrar.



FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 98
 County of Jefferson Primary Registration District No. 2176
 City of Regby (No. St.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 46
 Registered No. 46

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Stillborn
 (Write the word.)

6. DATE OF BIRTH Aug 15 1923
 (Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE Idaho
 (State or Country)

10. NAME OF FATHER C. J. Stonehocker

11. BIRTHPLACE OF FATHER Neb.
 (State or Country)

12. MAIDEN NAME OF MOTHER Frances Hill

13. BIRTHPLACE OF MOTHER Idaho
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. J. Stonehocker
 (Address) Regby Idaho

15. Filed 12-10-23 Ray H Fisher
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 15 1923
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 19..... to 19.....
 that I last saw h..... alive on 19.....
 and that death occurred on the date stated above, at..... M.
 The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory.....
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. M. Palmer M. D.

8-16-23 (Address) Regby

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL Regby

DATE OF BURIAL
8-16-23

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

499-230027-247

PLACE OF BIRTH

RECEIVED STATE OF IDAHO
BUREAU OF VITAL STATISTICSCounty of JeromeCity of Jerome

No. _____ St. _____

JAN 8 1923
BUREAU OF VITAL STATISTICS
Registration District No. 23File No. 118108

Hospital _____

Primary Registration District No. 2017

Registered No. _____

FULL NAME OF CHILD

unnamed DribergerSex of
Child7Twin
Triplet
or other?

— and —

Number
in order
of birth

—

Legiti
mate?yesDate of
BirthSept 3019 23

(Month) (Day) (Year)

FULL
NAMEFATHER
Joe Driberger

RESIDENCE

Jerome Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY30
(Years)

BIRTHPLACE

Holland

OCCUPATION

FarmerFULL
MAIDEN
NAMEMOTHER
Edith Super

RESIDENCE

Jerome Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY33
(Years)

BIRTHPLACE

Idaho

OCCUPATION

House wifeNumber of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born, at 4 P. M.
on the date above stated. (Born alive or stillborn)*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

E. D. Piper M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Jerome

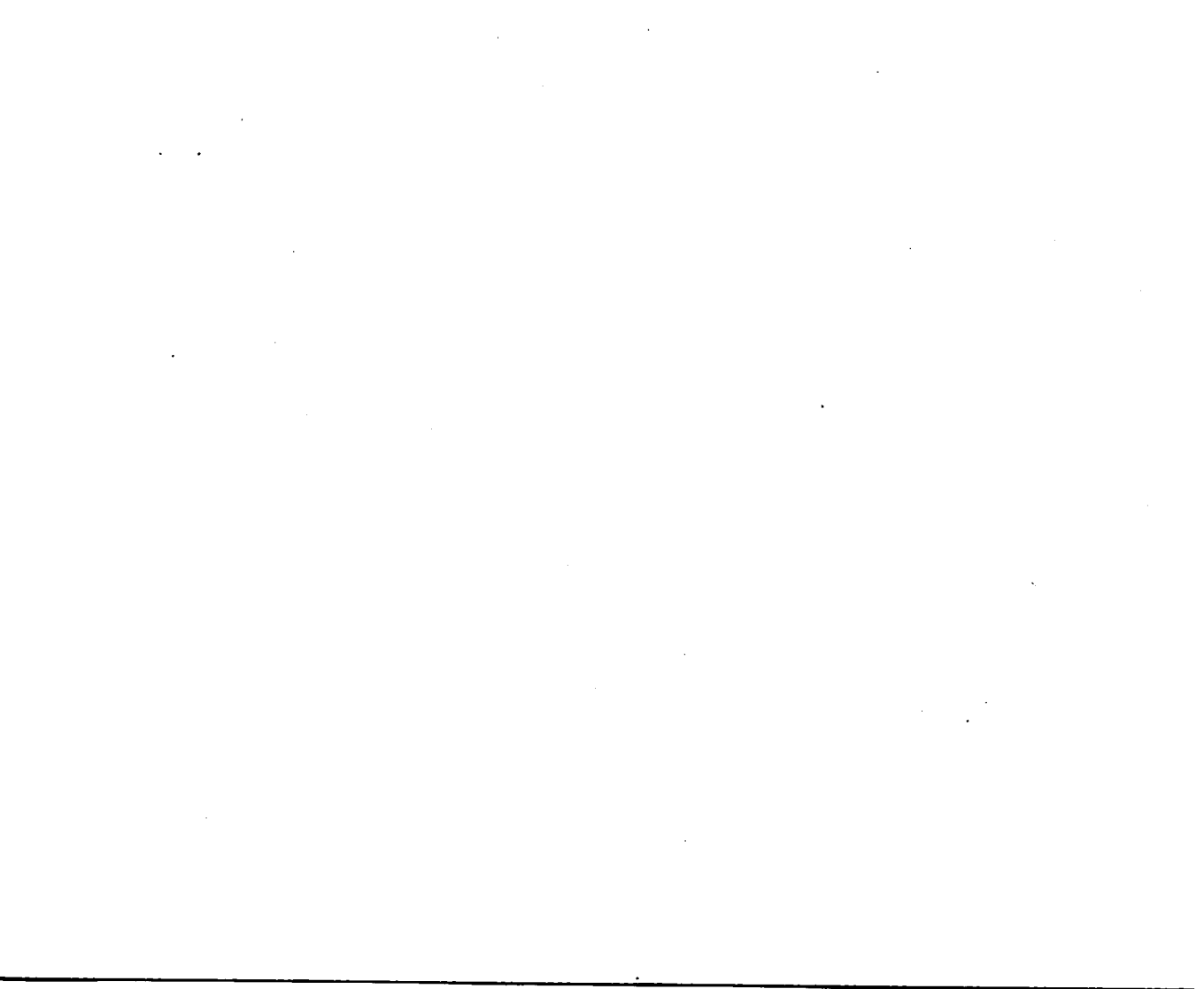
Filed

Dec 16 1923E. D. Piper M.D.

Registrar

Registrar

WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.



249-221-027-893

PLACE OF BIRTH

JAN 8 1924

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

County of Jerome

BUREAU OF VITAL STATISTICS

S

City of JeromeRegistration District No. 23

File No.

118111

No. _____ St. _____

Hospital _____

Primary Registration District No. 1017

Registered No. _____

FULL NAME OF CHILD

Bewlah Rose Burris

Sex of Child

7Twin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?yesDate of
BirthNov 211923

(To be answered only in event of plural births)

(Month) (Day) (Year)

FULL
NAME

FATHER

Edward BurrisFULL
MAIDEN
NAME

MOTHER

Esther Miller

RESIDENCE

Jerome Idaho

RESIDENCE

Jerome Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY23

(Years)

COLOR

whiteAGE AT LAST
BIRTHDAY18

(Years)

BIRTHPLACE

Oklahoma

BIRTHPLACE

Prince Geo. - N. Dak.

OCCUPATION

Flour Miller

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.Still born, at 10 P. M.

(Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

E. D. Piper M.D.

Given names added from a supplemental report.

19

Address

Jerome Idaho

Filed

Nov 22 1923E. D. Piper M.D.

Registrar

Registrar

101 1 7 21 4 7 8

101 1 7 21 4 7 8

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

JAN 31 1924

Boise, Idaho _____ 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

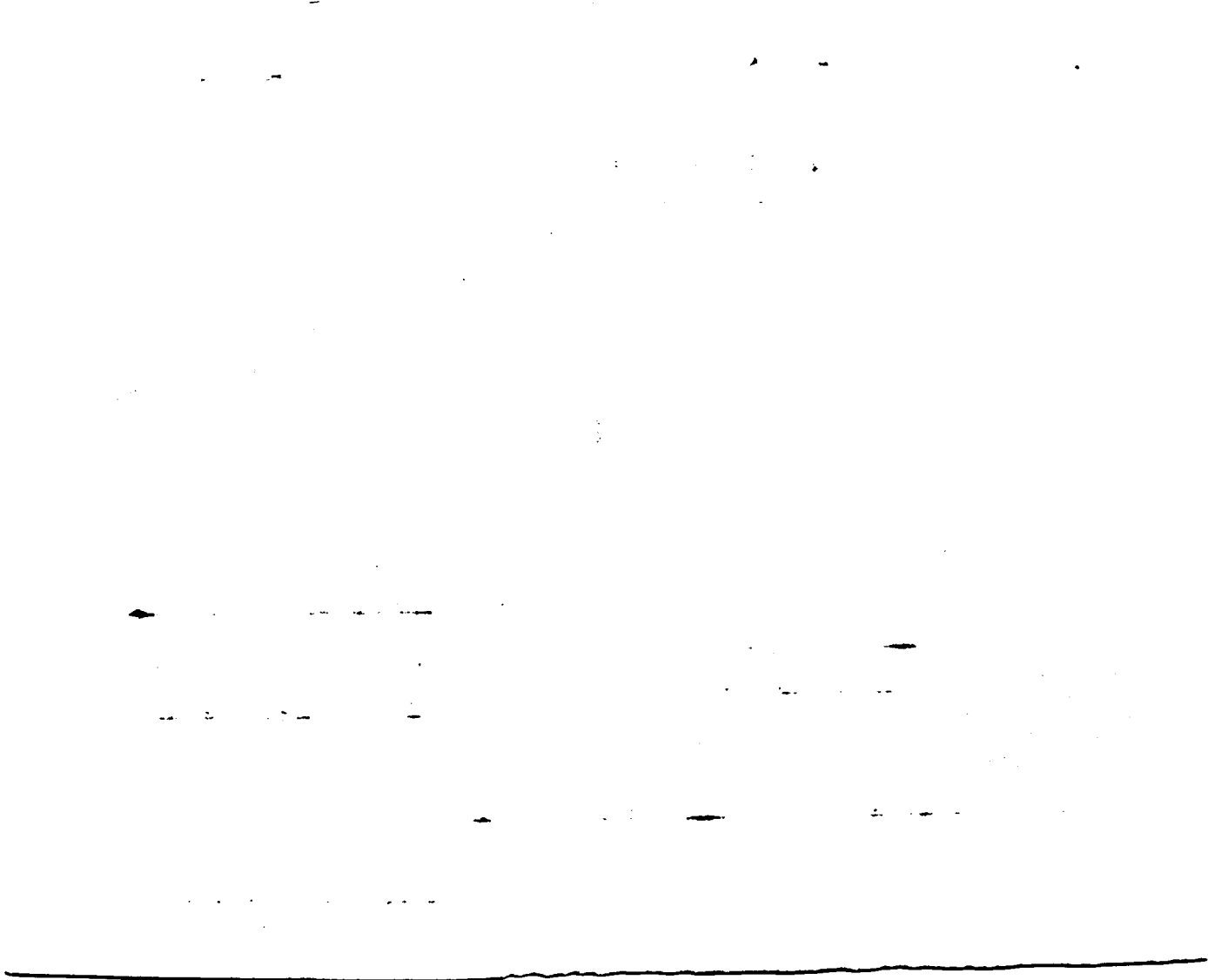
Place of Birth (CITY Jerome FILE NO. 118111
 (ST. _____ DATE OF BIRTH Nov 21 - 1923
 (COUNTY Jerome SEX OF CHILD Female
 FATHER Edward Burrus MOTHER Esther Miller
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Berulah Rose Burrus

Edward Burrus

Signature of Father or Mother.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Jerome*
City of *Jerome*Registration District No. *23*
Primary Registration District No. *1012-2017*
(No. _____ St.)File No. *44118*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

unnamed Burris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Nov 21 1923
(Month) (Day) (Year)

7. AGE

*Yrs. Mos. ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

Jerome Idaho

10. NAME OF FATHER

Edward Burris

11. BIRTHPLACE OF FATHER

(State or Country)

Oklahoma

12. MAIDEN NAME OF MOTHER

Ester Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Ester Miller

(Address)

Jerome Idaho

15.

Filed

*Nov 22 1923**E. D. Piper M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 21 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 21 1923 to *Nov 21 1923*

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at *10 P. M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

*E. D. Piper M.D.**22/219 23*

(Address)

Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Jerome Idaho**Nov 22 1923*

20. UNDERTAKER

ADDRESS

*D. A. Harrison**Jerome Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

319-206-070-238

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lewia

JAN 14 1924

CERTIFICATE OF BIRTH

City of Salmon

No. St.

Registration District No. 41

State File No. 118182

Hospital

Primary Registration District No. 2116

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin <u>no</u> or other? <u>no</u>	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Dec 6</u> 192 <u>43</u> (Month) (Day) (Year)
----------------------------	------------------------------------	--------------------------------	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FULL NAME <u>Charles Carlson</u>	FATHER
RESIDENCE <u>Salmon</u>	
COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>54</u> (Years)
BIRTHPLACE <u>Sweden</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Babe Schlemper</u>	MOTHER
RESIDENCE <u>Salmon</u>	
COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Id</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born at Stillborn } at 9th St. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. Wright M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Salmon
Filed 1-10 192 4 M. D. Greene

Registrar.

Registrar.

Affidavit to add name to live twin mistakenly attached to stillborn twin
Reversed on 3/28/11 by Name removed from Stillborn which was listed
as Bertha Mae - same as live twin

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44143

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Lemhi
City of Lahman

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 41
Primary Registration District No. 2116
(No. _____) St. _____Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

12 - 6 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Lahman

10. NAME OF FATHER

Charles Carlson

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Bertha Schilinger

13. BIRTHPLACE OF MOTHER

(State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Carlson(Address) Lahman, Idaho

15.

Filed 1-10 1924 M. D. Hume
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 - 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____

that I last saw him alive on 19____

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Stillborn
Suffocation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. S. Wright M. D.1-10 1924 (Address) Lahman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

19____

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
214-116-9030-258
County of Franklin
City of Baker
No. St. Registration District No. State File No.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JAN 14 1924
CERTIFICATE OF BIRTH

S

Hospital Primary Registration District No. 2116 Local Registrar's No.

FULL NAME OF CHILD.....

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 16</u> 192 <u>2</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>One</u>		Number of child of this mother now living, including present birth <u>One</u>	
FULL NAME <u>Roland Kadletz</u>	FATHER	FULL MAIDEN NAME <u>Minnie Snyder</u>	MOTHER
RESIDENCE <u>Baker</u>		RESIDENCE <u>Baker</u>	
COLOR <u>Wh</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	COLOR <u>Wh</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Ida</u>		BIRTHPLACE <u>Nebr</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Rescuable Stillborn at 3 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. S. Wright

(Physician or midwife)

Address Idaho

Filed 1-10 1924 M. D. Greene

Registrar.

Registrar.

REGISTRATION OF BIRTHS AND DEATHS
 The above and other returns shall be made in duplicate and one copy of each shall be retained in the office of the Registrar and the other copy shall be forwarded to the State Registrar of Births and Deaths, Department of Public Welfare, Bureau of Vital Statistics, State of Idaho.

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

County of Blaine
 City of Blaine
 Hospital Blaine
 Primary Registrar Blaine License No. Blaine
 Registration District No. Blaine Sub-district No. Blaine

Full Name of Child Blaine
 Sex of Child Blaine
 Date of Birth Blaine
 Time of Birth Blaine
 Place of Birth Blaine
 Name of Mother Blaine
 Name of Father Blaine

Color Blaine
 Birthplace Blaine
 Occupation Blaine
 Age at Last Birthday Blaine
 Color Blaine
 Birthplace Blaine
 Occupation Blaine
 Age at Last Birthday Blaine

Signature of Registrar Blaine
 Signature of Midwife Blaine
 Date Blaine

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child who was born on Blaine at Blaine and that the child was born alive and was born of a living woman.

When there was no attending physician or midwife then the parent, householder, or other person who has knowledge of the birth of the child, shall make this report. A birth record is one that is made by a person who is not a physician or midwife.

Give names added from a supplemental report.
 Registrar Blaine
 Date Blaine

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of LaramieCity of Salmon

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41Primary Registration District No. 2116(No. BUR St.)File No. 44142Registered No. 1 Kadlitz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

12 - 6 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Salmon, Idaho

10. NAME OF FATHER

Roland Kadlitz

11. BIRTHPLACE OF FATHER

(State or Country)

Baker, Idaho

12. MAIDEN NAME OF MOTHER

Minnie Snyder

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Roland Kadlitz
Salmon, Idaho

15.

Filed 1-10 1924 M.D. Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 - 16 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Stillborn)
hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. J. Wright M. D.1-2-1924 (Address) Salmon, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH. 463-1309 039 1913

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lemhi

City of Salmon

No. St.

Registration District No. 41

State File No. 118184

CERTIFICATE OF BIRTH

Hospital.....

Primary Registration District No. 2116

Local Registrar's No.

FULL NAME OF CHILD.....

Mock

(Certificate of no value without full name of child.)

Sex of Child	Male	Twin Triplet or other?		and	Number in order of birth	Legitimate?	yes	Date of birth	Nov 30	1923
					(To be answered only in event of plural births)			(Month)	(Day)	(Year)

What bactericidal solution was used in eyes? No
Number of child of this mother, including present birth 3
Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME	Clarence Mock	FULL MAIDEN NAME	Lelia Williams
RESIDENCE	Salmon	RESIDENCE	Salmon
COLOR	wh	COLOR	wh
AGE AT LAST BIRTHDAY	29 (Years)	AGE AT LAST BIRTHDAY	22 (Years)
BIRTHPLACE	Ida	BIRTHPLACE	Ida
OCCUPATION	Miner	OCCUPATION	Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE. 6 mo forth

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 12-50 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) JS Wright

(Physician or midwife)

Give names added from a supplemental report., 192.....

Address. Salmon Ida

Filed 1-10 1924 M. D. Greene

Registrar.

Registrar.

RECEIVED
JAN 14 1924

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Lehigh*City of *Lahman*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *41*Primary Registration District No. *2116*

(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *44146*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *1-10* 19 *24* *M. D. Greene*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11-30

(Month)

(Day)

19 *23*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 _____, to

19 _____

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *F. S. Wright*

M. D.

1-10-24 (Address) *Lahman, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. R.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

466-112-030-254
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lewia
City of Salmon
No. 41 Registration District No. 41 State File No. 118185
Hospital None Primary Registration District No. 2116 Local Registrar's No. None

FULL NAME OF CHILD None
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>None</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Nov 12</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	------------------------------------	-----	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? no
Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME <u>Burtis Moon</u>	FULL MAIDEN NAME <u>Silva Petronilla Sedovic</u>		
RESIDENCE <u>Baker</u>	RESIDENCE <u>Baker</u>		
COLOR <u>wh</u>	COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Id</u>	BIRTHPLACE <u>Id</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Wk</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born Stillborn at 1130 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. S. Wright

(Physician or midwife)

Give names added from a supplemental report.
....., 192.....
Registrar.

Address Salmon
Filed 1-10 1924 M. D. Greene
Registrar.

GEORGE T. LAMBERT, JR. at birth, was born on the 11th day of May, 1923, at the residence of his mother, Mrs. George T. Lambert, Jr., in the City of New York, State of New York, and was named after his father, George T. Lambert, Jr.

CERTIFICATE OF BIRTH

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

County of _____
 City of _____
 No. _____
 Registration District No. _____
 State File No. 118122
 Local Registrar's No. _____
 Primary Registration District No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child)
 Sex of Child _____
 Date of Birth _____
 (Month) (Day) (Year)
 Number and in order of birth _____
 (To be answered only in event of second birth)
 (Certificate of no value without full name of child)

If antiseptical solution was used in event _____
 Number of child in this mother, including present birth _____
 Number of child in this mother, including present birth _____

FATHER	MOTHER
RESIDENCE	RESIDENCE
COLOR	COLOR
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION
AGE AT LAST BIRTHDAY (Year)	AGE AT LAST BIRTHDAY (Year)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born _____ at _____
 on the date above stated.
 (Signature)
 (Signature of midwife)

*When there was no attending physician or midwife, then the father, householder, etc., should make the return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report _____
 Filed _____
 Registrar _____

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 44147
Registered No. _____

1. PLACE OF DEATH

County of Benewah
City of SalmonRegistration District No. 41
Primary Registration District No. 2116
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____
(Write the word.)

6. DATE OF BIRTH

11 - 12 1923
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Salmon, Idaho

10. NAME OF FATHER

Curtis Moore

11. BIRTHPLACE OF FATHER

(State or Country) Mo

12. MAIDEN NAME OF MOTHER

Silva Petronella Sedivis

13. BIRTHPLACE OF MOTHER

(State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Curtis Moore(Address) Salmon, Idaho

15.

Filed 1-10 1924 M. D. Hume
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 - 12 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Placenta previa

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. S. Wright1-10-24 (Address) Salmon, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

2191261031-438
BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 49 State File No. 118201

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD Baby Barnett

(Certificate of no value without full name of child.)

Sex of Child <u>in</u>	Twin Triplet or other? _____	and { } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>12/26</u> 19 <u>33</u> (Month) (Day) (Year)
------------------------	------------------------------	--	------------------------	---

What bactericidal solution was used in eyes? new

Number of child of this mother, including present birth 1st Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME <u>Guy M. Barnett</u>	FULL MAIDEN NAME <u>Josephine M. Hines</u>		
RESIDENCE <u>Kamiah</u>	RESIDENCE <u>Kamiah</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY _____ (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY _____ (Years)
BIRTHPLACE _____		BIRTHPLACE _____	
OCCUPATION <u>Prof. High School</u>		OCCUPATION <u>House</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 230 A M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) C. J. Johnson, M.D.
(Physician or midwife)

Address Kamiah
Filed 12/26 1933 C. J. Johnson
Registrar.

Registrar.

b)

1)

1977-1978

1978-1979

1979-1980

1980-1981

1981-1982

1982-1983

1983-1984

1984-1985

1985-1986

1986-1987

1987-1988

1988-1989

1989-1990

1990-1991

1991-1992

1992-1993

1993-1994

1994-1995

1995-1996

1996-1997

1997-1998

1998-1999

1999-2000

2000-2001

2001-2002

2002-2003

2003-2004

2004-2005

2005-2006

2006-2007

2007-2008

2008-2009

2009-2010

2010-2011

2011-2012

2012-2013

2013-2014

2014-2015

2015-2016

2016-2017

2017-2018

2018-2019

2019-2020

2020-2021

2021-2022

2022-2023

2023-2024

2024-2025

2025-2026

2026-2027

2027-2028

2028-2029

2029-2030

2030-2031

2031-2032

2032-2033

2033-2034

2034-2035

2035-2036

2036-2037

2037-2038

2038-2039

2039-2040

2040-2041

2041-2042

2042-2043

2043-2044

2044-2045

2045-2046

2046-2047

2047-2048

2048-2049

2049-2050

2050-2051

2051-2052

2052-2053

2053-2054

2054-2055

2055-2056

2056-2057

2057-2058

2058-2059

2059-2060

2060-2061

2061-2062

2062-2063

2063-2064

2064-2065

2065-2066

2066-2067

2067-2068

2068-2069

2069-2070

2070-2071

2071-2072

2072-2073

2073-2074

2074-2075

2075-2076

2076-2077

2077-2078

2078-2079

2079-2080

2080-2081

2081-2082

2082-2083

2083-2084

2084-2085

2085-2086

2086-2087

2087-2088

2088-2089

2089-2090

2090-2091

2091-2092

2092-2093

2093-2094

2094-2095

2095-2096

2096-2097

2097-2098

2098-2099

2099-2100

2100-2101

2101-2102

2102-2103

2103-2104

2104-2105

2105-2106

2106-2107

2107-2108

2108-2109

2109-2110

2110-2111

2111-2112

2112-2113

2113-2114

2114-2115

2115-2116

2116-2117

2117-2118

2118-2119

2119-2120

2120-2121

2121-2122

2122-2123

2123-2124

2124-2125

2125-2126

2126-2127

2127-2128

2128-2129

2129-2130

2130-2131

2131-2132

2132-2133

2133-2134

2134-2135

2135-2136

2136-2137

2137-2138

2138-2139

2139-2140

2140-2141

2141-2142

2142-2143

2143-2144

2144-2145

2145-2146

2146-2147

2147-2148

2148-2149

2149-2150

2150-2151

2151-2152

2152-2153

2153-2154

2154-2155

2155-2156

2156-2157

2157-2158

2158-2159

2159-2160

2160-2161

2161-2162

2162-2163

2163-2164

2164-2165

2165-2166

2166-2167

2167-2168

2168-2169

2169-2170

2170-2171

2171-2172

2172-2173

2173-2174

2174-2175

2175-2176

2176-2177

2177-2178

2178-2179

2179-2180

2180-2181

2181-2182

2182-2183

2183-2184

2184-2185

2185-2186

2186-2187

2187-2188

2188-2189

2189-2190

2190-2191

2191-2192

2192-2193

2193-2194

2194-2195

2195-2196

2196-2197

2197-2198

2198-2199

2199-2200

2200-2201

2201-2202

2202-2203

2203-2204

2204-2205

2205-2206

2206-2207

2207-2208

2208-2209

2209-2210

2210-2211

2211-2212

2212-2213

2213-2214

2214-2215

2215-2216

2216-2217

2217-2218

2218-2219

2219-2220

2220-2221

2221-2222

2222-2223

2223-2224

2224-2225

2225-2226

2226-2227

2227-2228

2228-2229

2229-2230

2230-2231

2231-2232

2232-2233

2233-2234

2234-2235

2235-2236

2236-2237

2237-2238

2238-2239

2239-2240

2240-2241

2241-2242

2242-2243

2243-2244

2244-2245

2245-2246

2246-2247

2247-2248

2248-2249

2249-2250

2250-2251

2251-2252

2252-2253

2253-2254

2254-2255

2255-2256

2256-2257

2257-2258

2258-2259

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Lewis
City of Hamiah

If death occurs away from
usual residence, give facts
called for under special in-
formation.

CERTIFICATE OF DEATH

Registration District No. 49
Primary Registration District No. 448
(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 44151
Local Registrar's No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME Baby Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

(Write the word)

6. DATE OF BIRTH

Dec. 26 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
0 hrs. or
0 min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Lewis County

10. NAME OF
Father

Guy S. Barnett

11. BIRTHPLACE
OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME
OF MOTHER

Josephine McEwen

13. BIRTHPLACE
OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Guy S. Barnett
(Address) Hamiah, Idaho

15. Filed

12/26/23

19

W. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 26 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
above 19 to above 19,
that I last saw h..... alive on..... 19,
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Sore Burn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Johnson

M. D.

12/26/23 Address) Hamiah

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

East Elm

DATE OF BURIAL

12/26 1923

20. UNDERTAKER

W. Johnson

ADDRESS

Hamiah

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

395-209,025-419

PLACE OF BIRTH

County of IdahoCity of Gifford

No. St.

Hospital White's

FULL NAME OF CHILD

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-3-3-17

S

Registration District No. 96

File No. 118260Primary Registration District No. 1009

Registered No.

Sex of Child <u>girl</u>	Twin Triplet or other? <u>—</u> and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>Nov 9</u> 19 <u>23</u> (Month) (Day) (Year)
--------------------------	--	-----------------------------	---

FULL NAME <u>Edgar W. Lincoln</u>	FATHER
RESIDENCE <u>Gifford Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Laborer</u>	

FULL MAIDEN NAME <u>Mary G. Marshall</u>	MOTHER
RESIDENCE <u>Gifford</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Moscow Idaho</u>	
OCCUPATION <u>House wife</u>	

Number of child of this mother, including present birth... 4 Number of children of this mother now living, including present birth... 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 10:24 M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

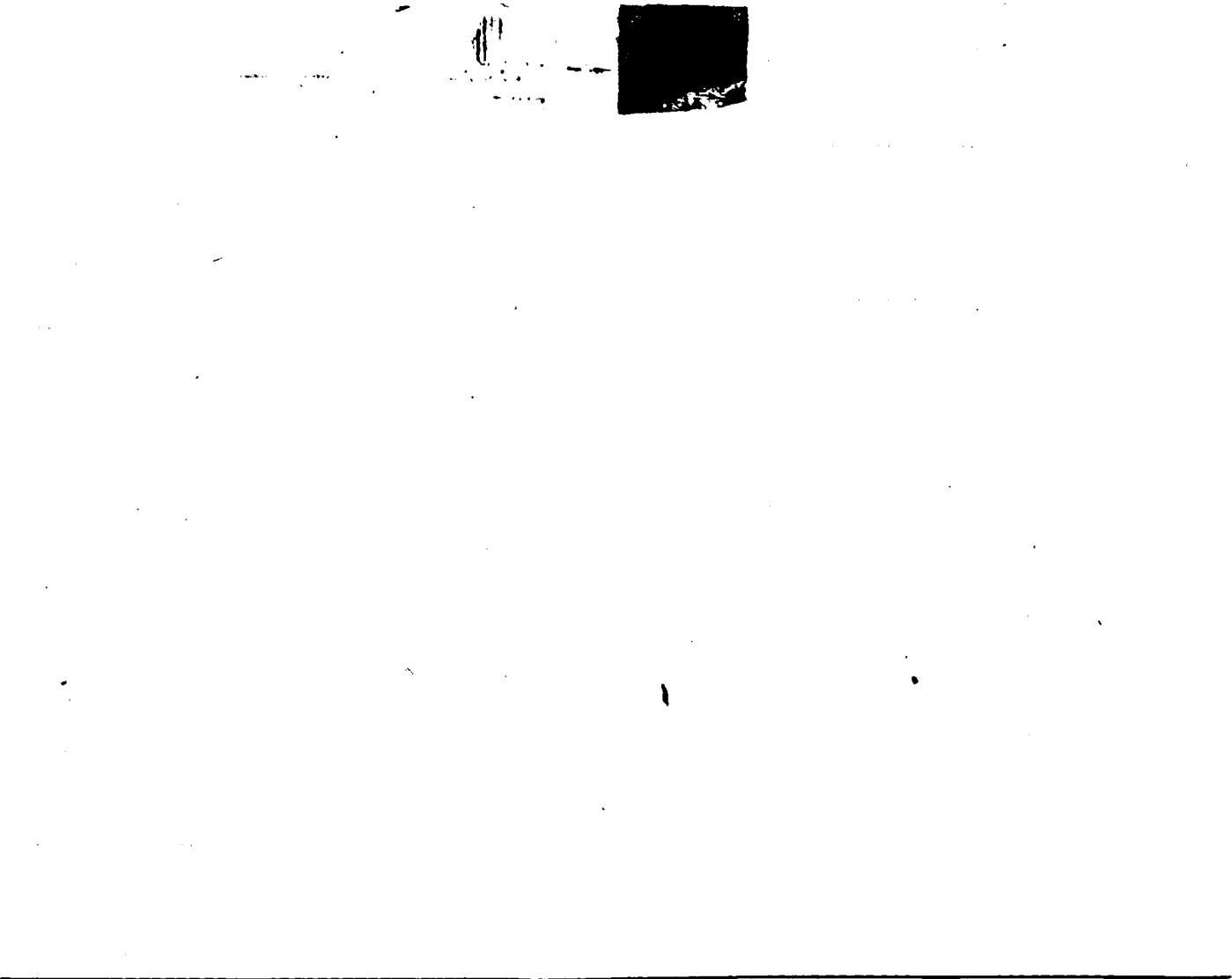
(Signature) Edgar P. White

Given names added from a supplemental report.

Address Reverston IdahoFiled Dec 23 1923 Simon E. Prince

Registrar

Registrar



69 PLACE OF BIRTH 1291035-862

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Nez Perce

City of Newport

No. 806 Birth St.

Registration District No. 96

State File No. 118272

Hospital

Primary Registration District No. 1209

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Nov. 29</u> , 192 <u>3</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	---

What bactericidal solution was used in eyes? (Yes) Argyl 20%

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Milton Sylvester Williams

RESIDENCE Newport Ida

COLOR White AGE AT LAST BIRTHDAY 23 (Years)

BIRTHPLACE Iowa

OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Sylvia Hopkins

RESIDENCE Newport Ida

COLOR White AGE AT LAST BIRTHDAY 23 (Years)

BIRTHPLACE Kentucky

OCCUPATION Housewife & Stenographer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born-alive at 12 30 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Edgar L. White M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Newport Ida

Filed

Dec 8 1923

Ernest E. Brown

Registrar.

Registrar.

4-14-64

10-11-64

U. S. DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF

QUASH TO DEATH

JOHN F. FORT

UNITED STATES DEPARTMENT OF JUSTICE

but:

TO DIRECTOR
FBI
WASHINGTON, D.C.

加拿大

25da
2.2.2.2

-13894
? 3700

100-443887-100

FATHER

Number of child of this woman including present birth

What constitutes a "new" collection?

2. Number of child of this mother now living, including a child born

ATTOM

REBUTTAL

COLOR

AGE AT DEATH
BIRTHDAY

(P. 11. 5. 7)

RESIDENCE

COL. 105

TRAJ TA EDA
YACHTIE

(b)(7)(C)

MOITA 9300

NO:TA9000

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

on the date above stated.

* When there was no attending physician or midwife from the Fatherhouse, the following would be called: a stillborn child as one that neither breathes nor shows other evidence of life after birth.

החלטת המועצה להקמת מועצה להגנה על המורשת

291

Исследования

1954

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 1924 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

BUREAU OF VITAL STATISTICS.

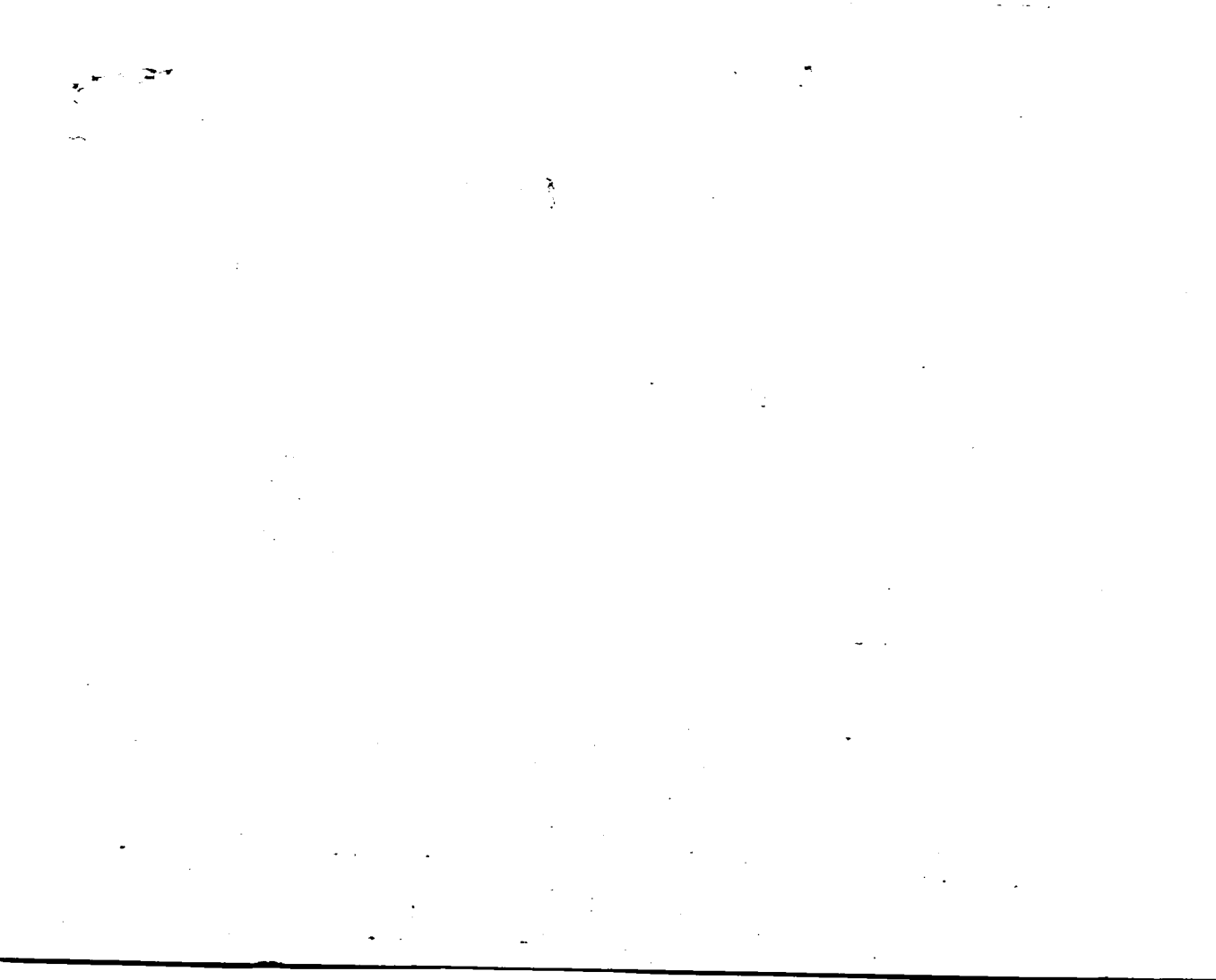
* * * * *

Place of Birth (CITY Lewiston FILE NO. 118272
(ST. 806 - 9 ave DATE OF BIRTH Nov. 29 - 23
(COUNTY Nezperce SEX OF CHILD Male
FATHER Milton Williams MOTHER Sylvia Haskin Williams
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

The child was born at the age of five months and was not named.

RECEIVED



WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No. 96

County of *Butte*

DEC 29 Primary Registration District No. 1109

City of *Lewiston*

BUREAU OF
STATISTICS

(St.)

File No.

44198

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single

(Write the word.)

6. DATE OF BIRTH

11 29 1923
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Mr. S. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Sylvia Hoeking

13. BIRTHPLACE OF MOTHER

(State or Country)

Ny.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. S. Williams

(Address)

Lewiston

15.

Filed *Dec 10* 19 *23*

Wm E. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 29 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-29 1923 to *11-29 1923*

that I last saw him *alive* on *11-29 1923*

and that death occurred on the date stated above, at *11* M.

The CAUSE OF DEATH* was as follows:

Still born.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Insurance)

(Duration) yrs. mos. ds.

(Signed)

Edgar L. White M. D.

12-1 1923 (Address) *Lewiston Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida.

11-30 1923

20. UNDERTAKER

ADDRESS

Lawson Undertaking Co.

Lewiston Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

713-1291035-465
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nez Perce

DEC 22 1923

CERTIFICATE OF BIRTH

City of Lewiston

Registration District No. 95

File No. 118273

Hospital

Primary Registration District No. 1009

Registered No.

FULL NAME OF CHILD

William Pate
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>11-29-1923</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 4 ... Number of child of this mother now living, including present birth... 3 ...

FATHER
FULL NAME J. O. Pate
RESIDENCE Lewiston Orchards
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Kansas
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Mary E. Dove
RESIDENCE Lewiston Orchards
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Montana
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 1:30 P. M.
on the date above stated. (Born alive or stillborn)

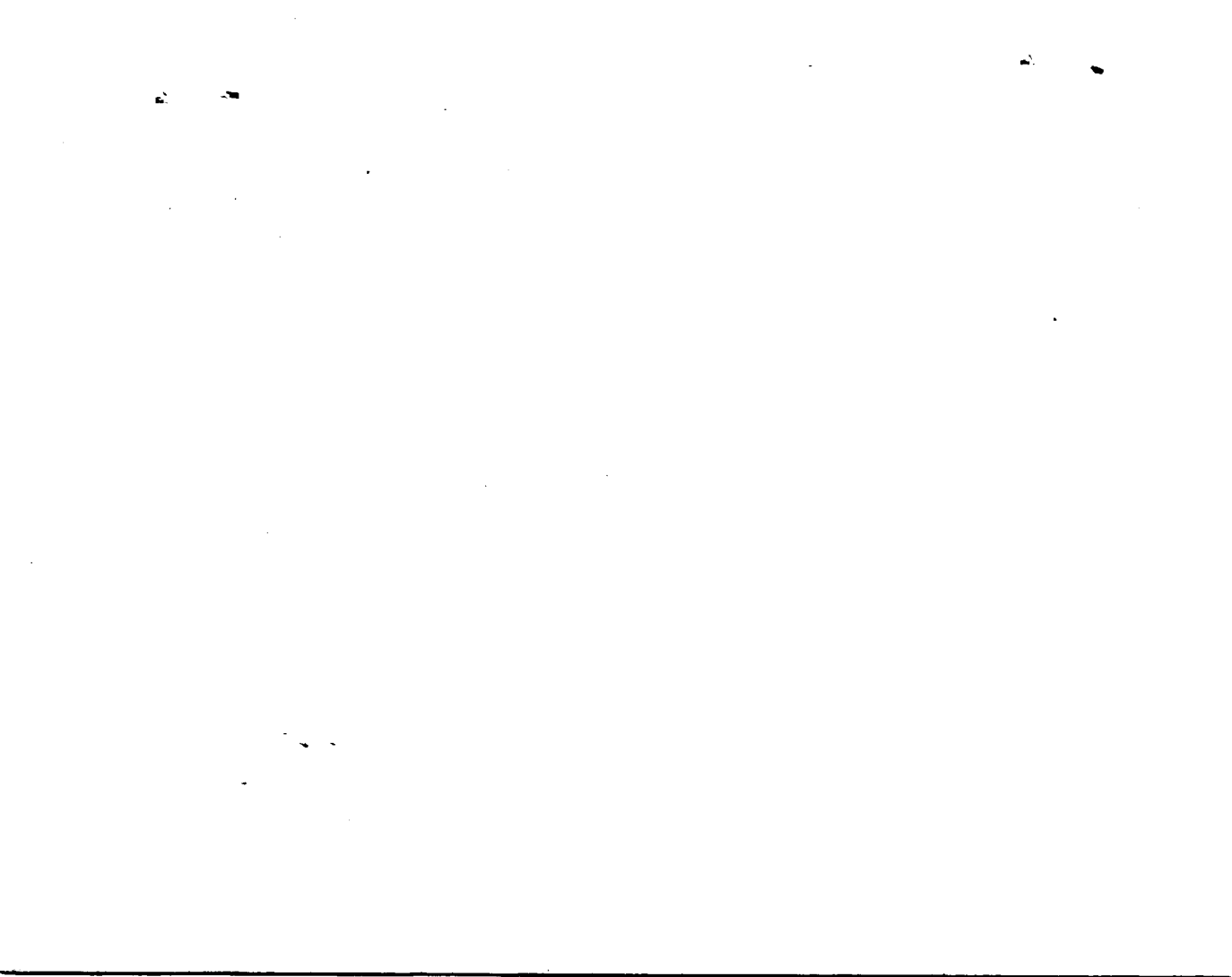
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O. C. Carson

(Physician or midwife)

Give names added from a supplemental report.
....., 19.....
Registrar.

Address Lewiston, Idaho
Filed Dec 2 1923 Susan E. Bruce
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Nez Perce
City of Lewiston Idaho

Registration District No. 95Registration District No. 1009(No. 1009 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44199

Registered No.

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

William Pate

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single

(Write the word.)

6. DATE OF BIRTH.

Jan 29 1902
(Month) (Day) (Year)

7. AGE

Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJ. O. Pate11. BIRTHPLACE
OF FATHER

(State or Country)

Kansas12. MAIDEN NAME
OF MOTHERMary E. Dore13. BIRTHPLACE
OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed Dec 10 1912 William C. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 29 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
.....191....., to191.....,

that I last saw him alive on191.....

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

Primative labor

(Duration) yrs. mos. ds.

(Signed) M. C. Carson M. D.

19. (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Waco, Texas

DATE OF BURIAL

Dec 1 1912

20. UNDERTAKER

Lewiston Ida

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

653-112.035-819
PLACE OF BIRTHSTATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-15

County of *Keg. Boree*

CERTIFICATE OF BIRTH

City of *Caldwell*Registration District No. *128*File No. *S 118292*

No. _____ St. _____

Primary Registration District No. _____

Registered No. _____

Hospital _____

Caldwell & vicinity

FULL NAME OF CHILD _____

Sex of Child <i>Male</i>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and } Number in order of birth _____	Legitimate? <i>yes</i>	Date of Birth <i>11 12 1923</i> (Month) (Day) (Year)
FULL NAME <i>William R. Bellows</i>	FATHER		FULL MAIDEN NAME <i>Edna H. Hart</i>	MOTHER
RESIDENCE <i>Caldwell Idaho</i>			RESIDENCE <i>Caldwell Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>23</i> (Years)		COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>21</i> (Years)
BIRTHPLACE <i>Oregon</i>			BIRTHPLACE <i>Oregon</i>	
OCCUPATION <i>Truck Driver</i>			OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth *3*Number of children of this mother now living, including present birth *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

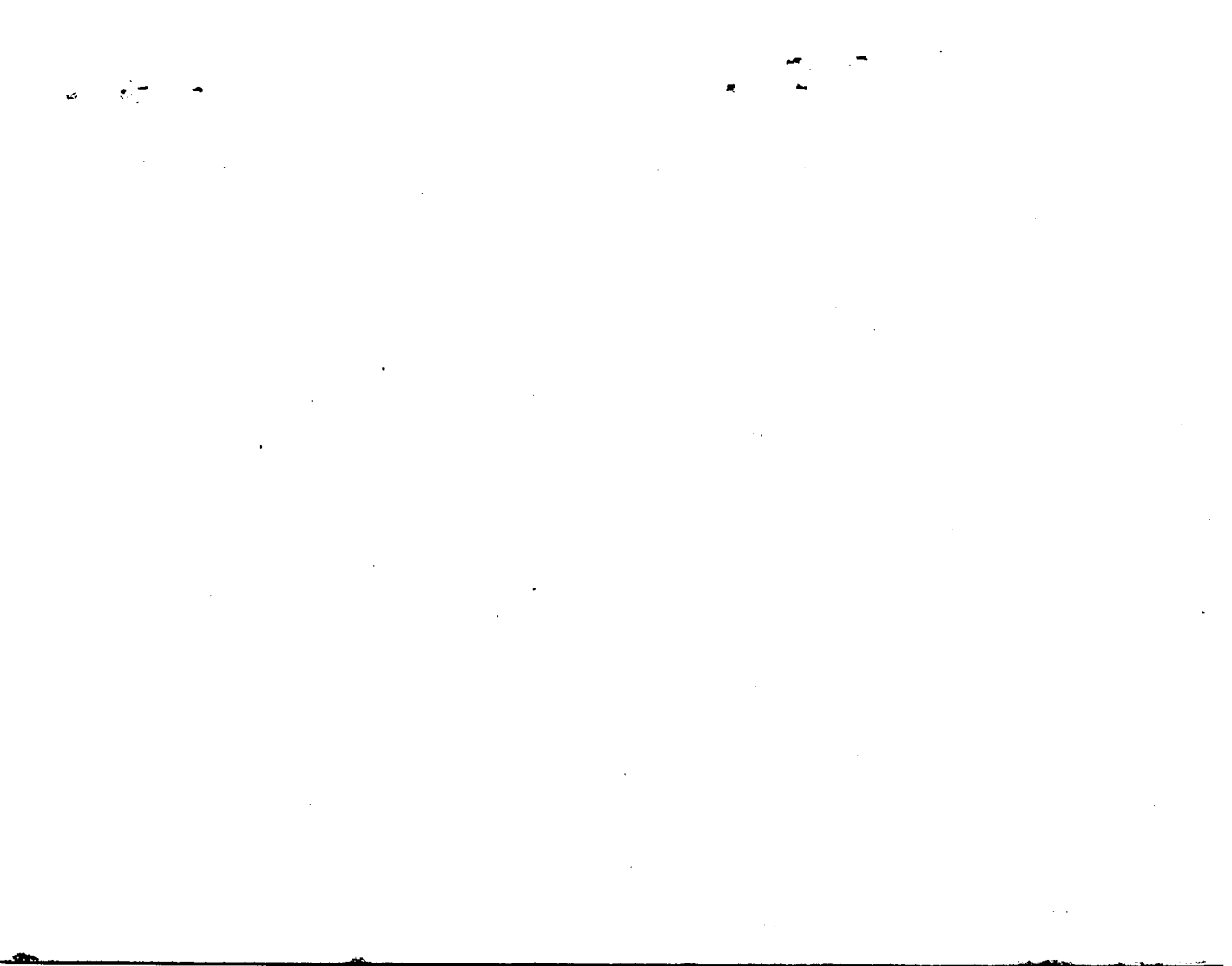
I hereby certify that I attended the birth of this child, who was _____
on the date above stated.*Stillborn* at *3:00 P. M.*
(Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *George Gagnard*
Physician
(Physician or midwife)

Given names added from a supplemental report.

Address *Caldwell Idaho*
Filed *Nov. 23* *George Gagnard*
Registrar



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 128
County of Perce Primary Registration District No. _____
City of Caldwell Ida (No. Caldwell & vicinity St.)

File No. 44179
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Write the word.)

6. DATE OF BIRTH

Nov. 12 1923
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William A. Bellows

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Edna H. Hart

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Bellows

(Address)

Caldwell Ida

15.

Filed Nov. 1923

George Gaismard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 12 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____

that I last saw h. _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) George Gaismard M. D.

Nov. 1923 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldwell Ida

Nov 13 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

314-05-030-243

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 18329

County of ShureCity of Idaho FallsRegistration District No. 84

File No. _____

No. _____ St. _____

Primary Registration District No. 2000 Registered No. 48

Hospital _____

FULL NAME OF CHILD

Thomas Jefferson Ladd

Sex of Child

MaleTwin
Triplet
or other?

{ and

Number
in order
of birth

Legitimate?

yes

Date of Birth

Dec 51923
(Month) (Day) (Year)

FULL NAME

Jefferson Agasson Ladd

FATHER

RESIDENCE

Idaho Falls

COLOR

white

AGE AT LAST BIRTHDAY

28

(Years)

BIRTHPLACE

Indian Res. Texas

OCCUPATION

Truck Driver

FULL MAIDEN NAME

Thelma Sullivan

MOTHER

RESIDENCE

Idaho Falls

COLOR

white

AGE AT LAST BIRTHDAY

23

(Years)

BIRTHPLACE

Bauer de Lene Idaho

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born, at 8 A M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. A. P. Hamilton
Physician

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Idaho Falls, Idaho

Filed

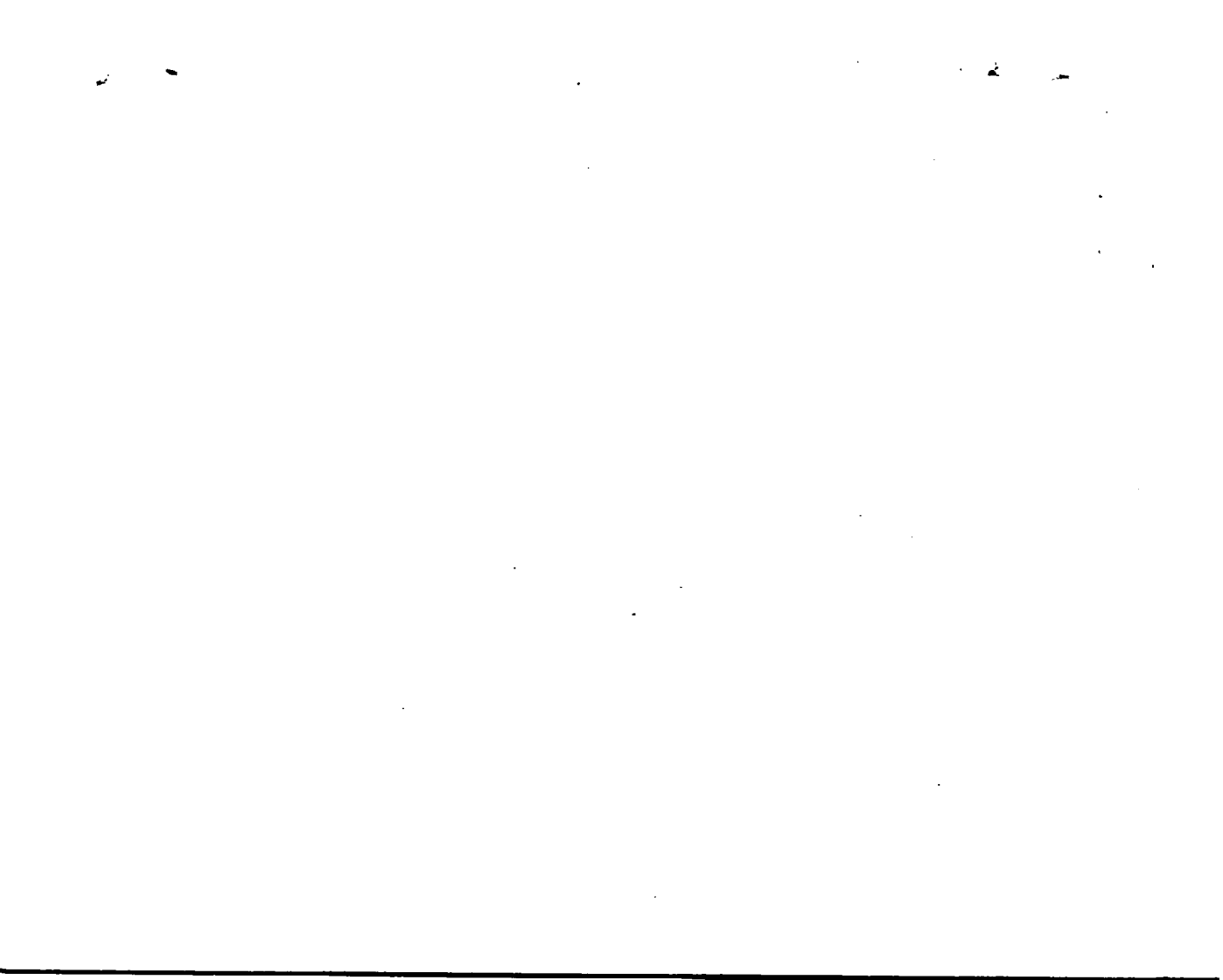
Dec 29, 1923S. A. Little

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Blaine
City of Mountain Home

Registration District No. 34

Primary Registration District No. 2040

St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Jefferson Ladd

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44063
Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

December 5 1923
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mt. Home Idaho

10. NAME OF FATHER

Jeff Ladd

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Delma Sullivan

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Ladd
Mt. Home Idaho

15.

Filled Dec 6 1923

D. A. Ulmer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still Born Dec 5 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... 19...
that I last saw him Still Born have on Born 19...
and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. P. Hamilton M. D.

12-5-1923 (Address) Mt. Home, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt. Home Cemetery

DATE OF BURIAL

Dec 6 1923

20. UNDERTAKER

Wm Mc Bratney

ADDRESS

Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

418-216.040-136

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 118398

County of Shoshone

City of Wallace

Registration District No. 70

File No. _____

No. _____ St. _____

Primary Registration District No. 1011

Registered No. 148

Hospital Wallace

FULL NAME OF CHILD (Died...) Maydahl

Sex of Child <u>7</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>21</u>	Legitimate? <u>yes</u>	Date of Birth <u>Oct 16 1923</u> (Month) (Day) (Year)
-----------------------	-----------------------------------	------------------------------------	------------------------	--

FATHER
FULL NAME Walter Albin Maydahl
RESIDENCE Wallace
COLOR white AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Minnesota
OCCUPATION Car Repairer

MOTHER
FULL MAIDEN NAME Joy Constantine Coam
RESIDENCE Wallace
COLOR white AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Chicago, Ill.
OCCUPATION housekeeper

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at _____ M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Walter T. Smith

(Physician or midwife)

Given names added from a supplemental report. _____ 19 _____

Address _____
Filed Oct 30 19 23 FL Smiley
Registrar

Registrar

11-00000

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho JAN 1 1924 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Wallace FILE NO. 118398
(ST. Idaho DATE OF BIRTH Oct. 16, 1923
(COUNTY Shoshone SEX OF CHILD Female
FATHER Walter A. Maydahl MOTHER Joy Acoam
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

The child died immediately after birth and
so was not named

RECEIVED

FEB 1 1924

W. A. Maydahl

Signature of Father or Mother

CONFIDENTIAL - SECURITY INFORMATION
This document contains information that is exempt from public release under the Freedom of Information Act, 5 U.S.C. 552, because its disclosure could result in the identification of a confidential source of information and thus be injurious to the national defense.

For the purpose of this document, the term "national defense" is defined as the defense of the United States against foreign aggression or subversion. The information contained herein is being furnished to you for your information only and is not to be distributed outside your agency without the express written approval of the originating agency.

The information contained herein is being furnished to you for your information only and is not to be distributed outside your agency without the express written approval of the originating agency. This document is being furnished to you for your information only and is not to be distributed outside your agency without the express written approval of the originating agency.

CONFIDENTIAL - SECURITY INFORMATION

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 5-15-17.

CERTIFICATE OF DEATH

44222

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 70

Primary Registration District No.

(No.

St.)

File No.

Registered No. 28

If death occurred in a hospital, institution or cemetery, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

DATE OF BIRTH.

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Still Born

(Duration)

Yrs.

mos.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

(Signed)

(Address)

Wallace Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers, who receive a definite salary*) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. H.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

744-215-011-692
OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 118428

County of Letran
City of Driggs
No. 77 St. JAN 3 1924 Registration District No. 77 State File No. 104
Hospital Primary Registration District, No. 2176 Local Registrar's No. 104

FULL NAME OF CHILD (Stillborn)
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin <u> </u> Triplet <u> </u> or other? <u> </u>	and <u> </u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 15</u> , 19 <u>23</u> (Month) (Day) (Year)
----------------------------	--	---------------	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER	MOTHER
FULL NAME <u>Clarence E. Gammon</u>	FULL MAIDEN NAME <u>Jessie Weberg</u>
RESIDENCE <u>Driggs, Ida</u>	RESIDENCE <u>Driggs, Ida</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>31</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Carpenter</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:00 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192.....

(Signature) Chris J. Mast
Physician
(Physician or midwife)

Address Driggs, Ida
Filed 12/16/1923 Martha Marker
Registrar.

Registrar.

THIS IS A SUMMARY OF THE INFORMATION OBTAINED FROM THE ABOVE NAMED PERSONS AND IS NOT TO BE USED AS A SUBSTITUTE FOR THE ORIGINAL RECORDS.

Give names added from a supplemental report

After birth

breast not shown after extended

a stillborn child is not that father

holder should make this return

or mother from the latest house

When there was no attending physician or midwife

on the date above stated

I hereby certify that I attended the birth of this child on the date above stated

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

OCCUPATION _____

BIRTH PLACE _____

COLOR _____

AGE AT LAST BIRTHDAY _____

OCCUPATION _____

BIRTH PLACE _____

COLOR _____

AGE AT LAST BIRTHDAY _____

RESIDENCE _____

FATHER _____

MOTHER _____

NAME OF CHILD OF THIS MOTHER _____

NAME OF CHILD OF THIS MOTHER _____

DATE OF BIRTH _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

NAME OF CHILD OF THIS MOTHER _____

NAME OF CHILD OF THIS MOTHER _____

DATE OF BIRTH _____

DATE OF LAST BIRTHDAY _____

STATE OF _____

COUNTY OF _____

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho JAN 21 1923

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

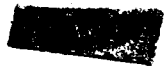
Place of Birth (CITY Driggs FILE NO. 118428
(ST. _____ DATE OF BIRTH Dec 21 1923
(COUNTY Teton SEX OF CHILD Female
FATHER C. E. Gunnerson MOTHER Jennie Wiberg
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

The baby was born dead and never was named

ms C. E. Gunnerson

Mother.



1941 10 10

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above.

I am sorry that I cannot give you a more definite answer at this time, but the matter is being handled as quickly as possible.

I am, Sir, very respectfully,
Yours,
[Signature]

Very truly yours,
[Signature]

Enclosed for you are the following documents:

1. [Description of document]

2. [Description of document]

3. [Description of document]

4. [Description of document]

5. [Description of document]

6. [Description of document]

7. [Description of document]

8. [Description of document]

9. [Description of document]

10. [Description of document]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 1-19.

1. PLACE OF DEATH

County of Teton
City of Driggs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Dec 15 1923
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Driggs, Idaho

10. NAME OF FATHER

Charles E. Gunnerson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Jemie Philup

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ch. E. Gunnerson
(Address) Driggs, Idaho

15.

Filed

Dec 15- 1923

Martha Markley
Local Registrar

CERTIFICATE OF DEATH

Registration District No. 77

County Registration District No. 2176

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44300

Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 13 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 13 1923 to Dec 15 1923
that I last saw him alive on Dec 13 1923
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Chas. E. Gunnerson M. D.
Dec 14 1923 (Address) Driggs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Driggs, Idaho

DATE OF BURIAL

12/14/ 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

553-115015 494
PLACE OF BIRTHRECEIVED
FEB 1 1924STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSS
118765

County of Caribou
City of Conda
No. _____ St. _____ Registration District No. 82 File No. _____
Hospital _____ Primary Registration District No. 2159 Registered No. 12

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>-</u> and <u>Number in order of birth</u> <u>✓</u>	Legitimate? <u>yes</u>	Date of birth <u>July 15</u> 192 <u>3</u> (Month) (Day) (Year)
--------------------------	--	------------------------	---

What bacteriocidal solution was used in eyes? DeadNumber of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME <u>Geo. Nelson</u>	FULL MAIDEN NAME <u>Edna Drubay</u>		
RESIDENCE <u>Conda</u>	RESIDENCE <u>Conda</u>		
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)		
BIRTHPLACE <u>Ida</u>	BIRTHPLACE <u>Utah</u>		
OCCUPATION <u>Barber</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:15 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Russell Fager

(Physician or midwife)

Give names added from a supplemental report.

Olis K. K. L. L., 19____
Registrar.Address Sada Sp. Co.Filed June 30 1924 Olis K. K. L. L.
Registrar.WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

10/10/10

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC

BUREAU OF VITAL STATISTICS

County of *Clearwater*

City of *Elk River*

No. *615 205 018 862*

St. Registration District No. *91*

State File No.

Hospital *Elk River*

Primary Registration District No. *2168*

Local Registrar's No. *34*

FULL NAME OF CHILD *Violet Juanita Favaro*

(Certificate of no value without full name of child)

Sex of Child *Female*

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate? *yes*

Date of
birth *Dec. 5*

1923

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *2*

Number of child of this mother now living, including present birth *2*

FULL
NAME

FATHER

Fortunato Favaro

RESIDENCE

Elk River, Ida.

COLOR

white

AGE AT LAST
BIRTHDAY

32

(Years)

BIRTHPLACE

Italy

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Lillian Hoset

RESIDENCE

Elk River, Ida.

COLOR

white

AGE AT LAST
BIRTHDAY

22

(Years)

BIRTHPLACE

Colfax Wisconsin

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { *Stillborn* } at *4:30 P.* M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. H. Neely
Physician
(Physician or midwife)

Address

Elk River, Idaho

Filed

Jan. 29 1924

Registrar.

Registrar.



RECEIVED
FEB 4 1924
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44416
Registered No. 10

1. PLACE OF DEATH. Registration District No. 91
County of Clearwater Principal Registration District No. 2168
City of Elk River (St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Violet Juanita Favaro

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
6. DATE OF BIRTH Dec. 5 1923
(Month) (Day) (Year)
7. AGE yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Elk River, Idaho.

10. NAME OF FATHER Fortunato Favaro

11. BIRTHPLACE OF FATHER (State or Country) Italy.

MAIDEN NAME OF MOTHER Lillian Fasel

BIRTHPLACE OF MOTHER Wisconsin

BE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Informant) Mrs. F. Favaro
(Address) Elk River, Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 5 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h alive on 191 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Still born.

(Duration) yrs. mos. ds.
Contributory (Secondary) 1
(Duration) yrs. mos. ds.
(Signed) J. H. Healy M. D.
Dec. 1923 (Address) Elk River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Elk River, Ida. Dec. 5 1923

20. UNDERTAKER ADDRESS

led Jan 29 1924 Mildred Hamby
Local Registrar

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway tra—accident*; *Revolver wound of head—homicide*; *Poison by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *se tetanus*) may be stated under the head of "Contribut

631 107 024 652

PLACE OF BIRTH

County of GoodingCity of Gooding

No. _____

Hospital _____

FULL NAME OF CHILD

Registration District No. 24

Primary Registration District No. _____

File No. 118848

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICSBUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTHSex of
ChildmaleTwin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?yesDate of
Birth3ep 719 23

(To be answered only in event of plural births)

(Month) (Day) (Year)

FULL
NAME

FATHER

George FlackFULL
MAIDEN
NAME

MOTHER

Emma Webb

RESIDENCE

Gooding Idaho

RESIDENCE

Gooding Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY42
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY32
(Years)

BIRTHPLACE

Iowa

BIRTHPLACE

Va -

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 7Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn
on the date above stated.

(Born alive or stillborn)

at 12²⁵ A M.*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

W. C. Cary MD

(Physician or midwife)

Given names added from a supplemental report.

19 _____

Address

Gooding Idaho

Filed

10-8-2319 23

Registrar

Registrar

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho April 1, 1923

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

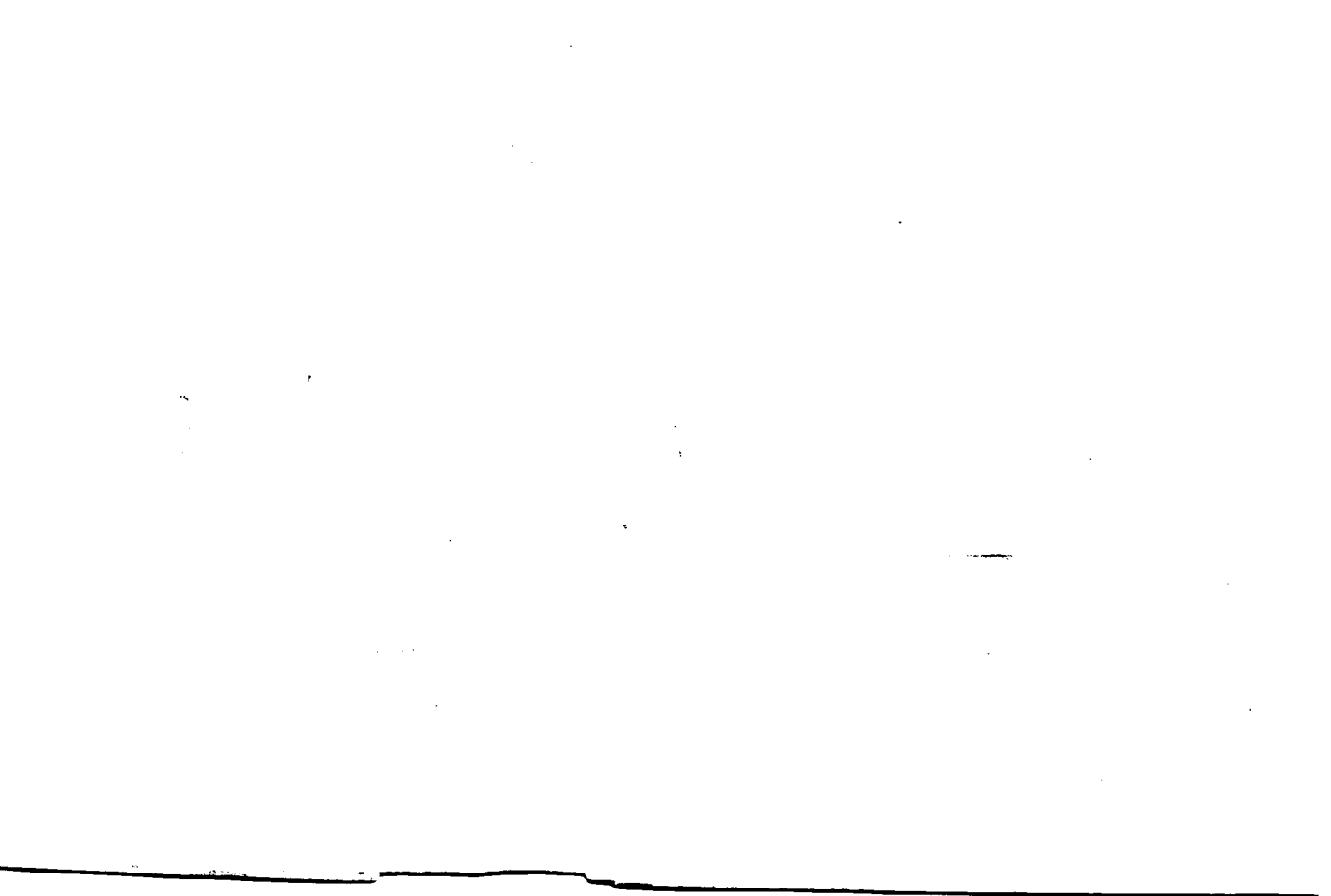
* * * * *

Place of Birth	(CITY	<u>Gooding</u>	FILE NO.	<u>118848</u>
	(ST.	<u>Idaho</u>	DATE OF BIRTH	<u>Sept 7, 1923</u>
	(COUNTY	<u>Gooding</u>	SEX OF CHILD	<u>Male</u>
	FATHER	<u>George Flack</u>	MOTHER	<u>Mrs. Emma Webb</u> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Hughy Allen FlackMrs. George Flack

Signature of Father or Mother.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44441

1. PLACE OF DEATH. Registration District No. ✓
County of Gooding Primary Registration District No. ✓
City of Gooding (State) Idaho St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BabyBlack

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sep 7 1923
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER George Black

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ewana Webb

13. BIRTHPLACE OF MOTHER (State or Country) Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Black
(Address) Gooding, Ida

15. Filed 9-8- 1923 Frank
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep 7 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Swear M. D. 9-7- 1923 (Address) Gooding, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

191

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS-

S

County of Nez PerceCity of BlackfootNo. 964-211035-414

RECEIVED

FEB 8 1924

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

93

State File No. 118999

Hospital.....

Primary Registration District No. 2371

Local Registrar's No.....

FULL NAME OF CHILD.....

Willie Burns

(Certificate of no value without full name of child.)

Sex of Child ?Twin
Triplet
or other?and { Number
in order
of birth

(To be answered only in event of plural births)

Legitimate? Yes

Date of birth

(Month)

(Day)

Nov 11, 1923

(Year)

What bactericidal solution was used in eyes? ✓Number of child of this mother, including present birth 2Number of child of this mother now living, including present birth 1

FULL NAME

FATHER

Edgar E. Rogers

RESIDENCE

Blackfoot, Idaho

COLOR

White

AGE AT LAST BIRTHDAY

6
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL MAIDEN NAME

MOTHER

Mildred E. Hansen

RESIDENCE

Blackfoot, Idaho

COLOR

White

AGE AT LAST BIRTHDAY

33
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Blackfoot, Idaho on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. H. Shirley

(Physician or midwife)

Address Blackfoot, IdahoFiled Feb 21

1923

Walter Lyle

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

1. The following information is to be furnished by the physician or midwife attending the birth of the child in black and white and should be filled in by the physician or midwife attending the birth of the child in black and white.

Give names added from a supplemental report.
 The child's birth
 A stillborn child is one that neither
 breathes nor shows other signs of
 life or vitality when the child is born.
 Both of these should be noted.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at St. Louis on March 11, 1933.

(Physician or midwife)

Address _____
 Phone _____
 Signature _____

PLACE OF BIRTH _____		COUNTY OF _____ STATE OF _____	
BIRTHPLACE _____		RESIDENCE _____	
AGE AT LAST BIRTHDAY (Y) _____		AGE AT LAST BIRTHDAY _____	
COLOR _____		COLOR _____	
BIRTHPLACE _____		BIRTHPLACE _____	
RESIDENCE _____		RESIDENCE _____	
NAME _____		NAME _____	
FATHER _____		FATHER _____	
MOTHER _____		MOTHER _____	
SEX _____		SEX _____	
DATE OF BIRTH _____		DATE OF BIRTH _____	
TIME OF BIRTH _____		TIME OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF BIRTH _____	
COUNTY OF _____		COUNTY OF _____	
STATE OF _____		STATE OF _____	

118333
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF HEALTH
 STATE OF MISSOURI

RECEIVED

FEB 8 1924

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Myer*City of *Peck*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *73*State of *Idaho* Registration District No. *2371*(No. *Stillborn*)

(St.)

File No. *44403*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *?* 4. COLOR OR RACE *White* 5. SINGLE, 'MARRIED, WID-
OWED OR DIVORCED *Stillborn*
(Write the word.)

6. DATE OF BIRTH

Dec 11 1923
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Edgar E. Rodger

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Mildred E. Danson

13. BIRTHPLACE OF MOTHER

(State or Country) *Arkansas*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Edgar E. Rodger*(Address) *Peck, Idaho*

15.

Filed *12/12* 19 *23* *Maice Lyle*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 11 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 11 1923* to *Dec 11 1923*
that I last saw him alive on *12*
and that death occurred on the date stated above, at *11-9 A.M.*
The CAUSE OF DEATH* was as follows:*Stillborn, undeveloped.*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. M. Fairly* M. D.*12/11 1923* (Address) *Peck, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Peck Cemetery

DATE OF BURIAL

12/12 1923

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

713-419 003-249

County of BannockCity of PocatelloNo. 234 N. Main St.

Hospital

FULL NAME OF CHILD

Registration District No. 25 State File No. 119302Primary Registration District No. 2161 Local Registrar's No. 6241Nick Pallotti

(Certificate of no value without full name of child)

Sex of Child	<u>boy</u>	Twin Triplet or other?	and {	Number in order of birth	Legiti- mate?	<u>yes</u>	Date of birth	<u>12/19</u>	<u>1923</u>
		(To be answered only in event of plural births)					(Month)	(Day)	(Year)

What bactericidal solution was used in eyes? 1% A.G. N/O/3Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME FATHER

Nick M Pallotti

RESIDENCE

234 N. MAIN

COLOR

whiteAGE AT LAST
BIRTHDAY23

(Years)

BIRTHPLACE

Pocatello

OCCUPATION

Machinist.FULL
MAIDEN
NAMEMary Burch

RESIDENCE

234 N. Main

COLOR

whiteAGE AT LAST
BIRTHDAY20

(Years)

BIRTHPLACE

Deer Lodge Montana.

OCCUPATION

Hawf

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 300 N. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

192

Registrar.

(Signature)

Dr. F. Howard M.D.

Physician.

(Physician or midwife)

Address

303 Carlsen Bldg.

Filed

2/1 1924

Registrar.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bannock*City of *Paerterville*

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. *234* N. 8 St.)

2. FULL NAME

*Infant Palatta*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *4392*Registered No. *9207*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *Station* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH

Dec 11 1923
(Month) (Day) (Year)

7. AGE

Stew Barn
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Nick Palatta

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Bush

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nick Palatta(Address) *234 N. 8 St.*

15.

Filed *12/12* 19*23*

Local Registrar

16. DATE OF DEATH

Dec. 11 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 11 1923 to *same* 19*23*
that I last saw him *when still born* 19*23*
and that death occurred on the date stated above.
The CAUSE OF DEATH* was as follows:*Parents Susan both
parents G. M. M. M.
Station*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. H. Hays
Pr. A. L. L. L.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Securus only
Schmuck, Ave. Pacatus
12/12 1923

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH
819-207003846
County of Bannock
City of Lago
No. _____ St. _____

RECEIVED
MAR 4 1924
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
BUREAU OF CERTIFICATE OF BIRTH
STATISTICS

S

Registration District No. 84 File No. 119356
Hospital _____ Primary Registration District No. 2161 Registered No. 89

FULL NAME OF CHILD Pauline Harriett Harris
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	<u>Twins</u> Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth <u>3rd</u>	Legitimate? <u>Yes</u>	Date of birth <u>4-7-</u> 192 <u>8</u> (Month) (Day) (Year)
----------------------------	--	---	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 8 ... Number of child of this mother now living, including present birth... 3 ...

FATHER		MOTHER	
FULL NAME <u>Guy Harris</u>	FULL MAIDEN NAME <u>Vera Huttard</u>	FULL NAME <u>Guy Harris</u>	FULL MAIDEN NAME <u>Vera Huttard</u>
RESIDENCE <u>Lago, Ida</u>	RESIDENCE <u>Lago, Idaho</u>	RESIDENCE <u>Lago, Idaho</u>	RESIDENCE <u>Lago, Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Lago, Ida</u>	BIRTHPLACE <u>Lago, Idaho</u>	BIRTHPLACE <u>Lago, Idaho</u>	BIRTHPLACE <u>Lago, Idaho</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. Huttard
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____
_____, 19____
_____, 19____

Address Grace, Idaho
Filed Mar-1-1924 Mrs. L. E. Fitz
Registrar.

24

9

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bainwick
City of Lago

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAR 1
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
Registration District No. 384
Primary Registration District No. 2161

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 44622Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White (Write the word.)

6. DATE OF BIRTH

4 - 7 - 1923
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Guy Harris

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Kerw Huttard

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Turner(Address) Lago, Idaho

15.

Filed 19 Ms g g Fitz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 - 7 - 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stellbarn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mrs. Mary Turner M. D.19 (Address) Midwife

*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lago 19

20. UNDERTAKER ADDRESS

had none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

366-229 010 366

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Bannerville RECEIVED STATE OF IDAHO
BUREAU OF VITAL STATISTICS

City of Ponca FEB 13 1924 CERTIFICATE OF BIRTH
BUREAU OF VITAL
Registration District No. 73

No. _____ St.

File No. 119466

Hospital _____

Primary Registration District No. 2140 Registered No. 22

FULL NAME OF CHILD

Sex of Child Female { Twin or other? } and { Number in order of birth } Legiti mate? no Date of Birth 12 29 23
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER		MOTHER	
FULL NAME	<u>?</u>	FULL MAIDEN NAME	<u>Jessie Lowe</u>
RESIDENCE	<u>?</u>	RESIDENCE	<u>Idaho Ida.</u>
COLOR	<u>?</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>?</u> (Years)	AGE AT LAST BIRTHDAY	<u>18</u> (Years)
BIRTHPLACE	<u>?</u>	BIRTHPLACE	<u>Idaho Falls</u>
OCCUPATION	<u>?</u>	OCCUPATION	<u>Working Domestics</u>

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

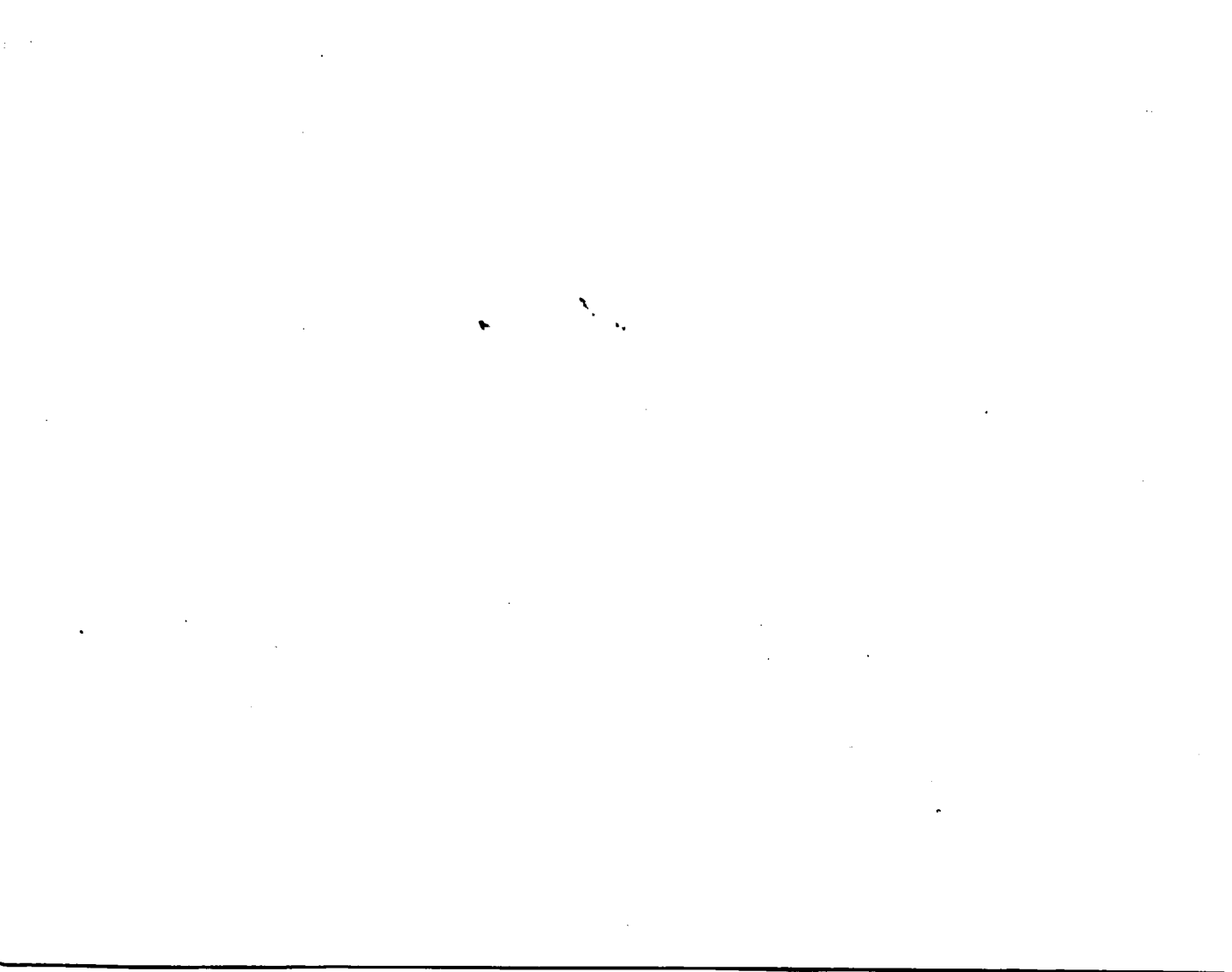
I hereby certify that I attended the birth of this child, who was born Premature at 12:30 A.M. on the date above stated. (If born a stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mrs R W Denning
midwife
(Physician or midwife)

Given names added from a supplemental report.

Address Ponca Idaho
Filed 1/12 1924 W. J. J. J.
Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

249-117015-286

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of CaribouCity of Soda Springs

No. _____

St. _____

Registration District No. 82File No. 119597

Hospital _____

Primary Registration District No. 2154Registered No. 36

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child MaleTwin
Triplet
or other? ☒

and

Number
in order
of birth 2Legiti-
mate? yesDate of
birth Nov. 17, 1923

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? yesNumber of child of this mother, including present birth 7Number of child of this mother now living, including present birth #3FULL
NAME

FATHER

Earnest H. SmithFULL
MAIDEN
NAME

MOTHER

Celia L. Short

RESIDENCE

Grange, Idaho

RESIDENCE

Grange, Id.

COLOR

white

AGE AT LAST

BIRTHDAY 38

(Years)

COLOR

white

AGE AT LAST

BIRTHDAY 33

(Years)

BIRTHPLACE

Ida

BIRTHPLACE

Ida

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:30 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) Russell Zigert

(Physician or midwife)

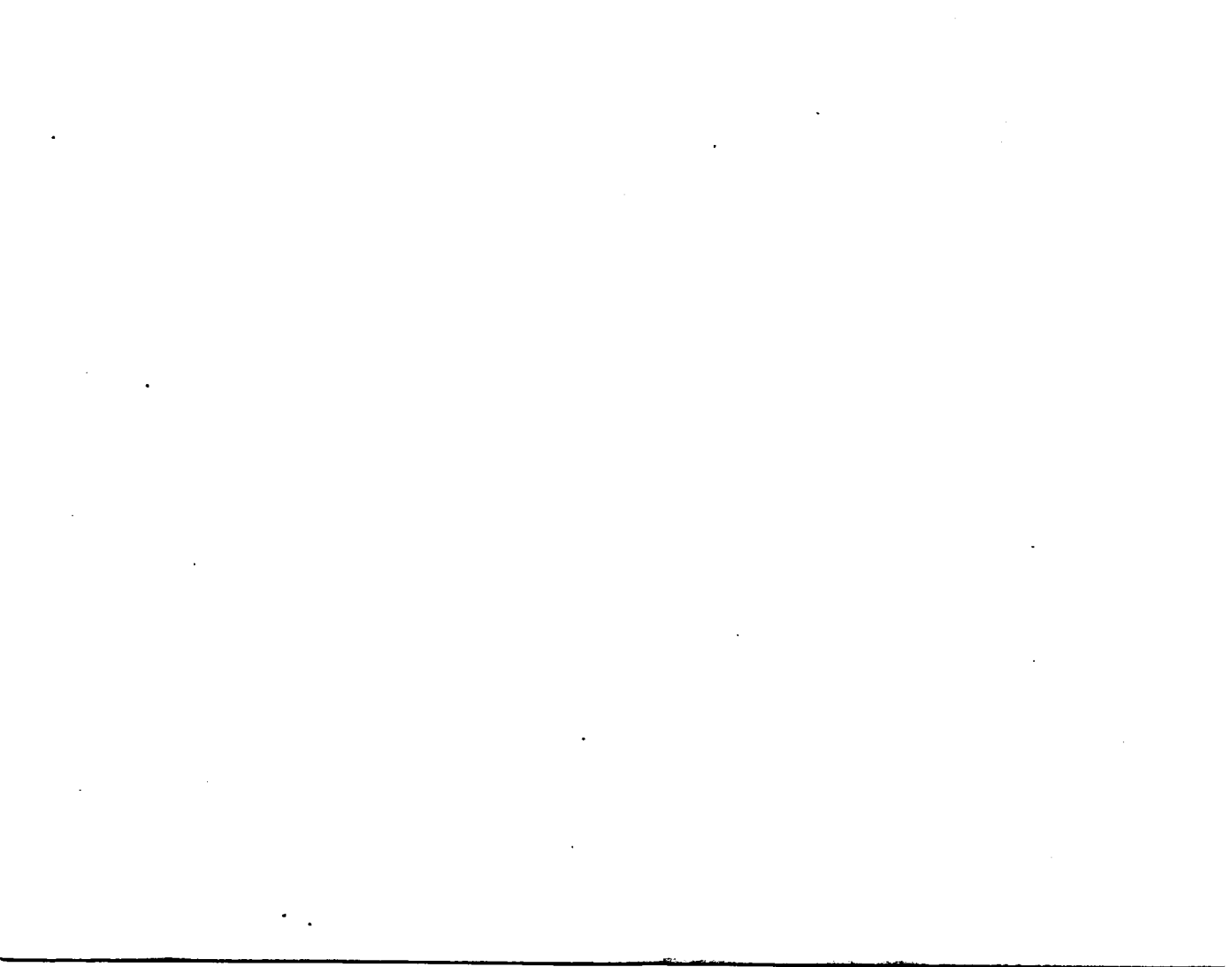
Give names added from a supplemental report.

Address Soda Springs, IdaFiled Nov 29, 1924

1924

Elmer K. Kirby

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

533-205 015 391
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

119605

County of Caribou

City of Sada Spgs.

No. — St. —

Registration District No. 82

File No. —

Hospital —

Primary Registration District No. 2159

Registered No. 428

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>F</u>	Twins or other? <u>✓</u> and { Number in order of birth <u>—</u> }	Legitimate? <u>yes</u>	Date of birth <u>Mar. 5</u> 192 <u>3</u> (Month) (Day) (Year)
-----------------------	--	------------------------	--

What bacteriocidal solution was used in eyes? —

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Geo. W. Ellis
RESIDENCE Sada Spgs.
COLOR White AGE AT LAST BIRTHDAY 54 (Years)
BIRTHPLACE Mo.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Susannah Trappett
RESIDENCE Sada Spgs.
COLOR White AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Ut.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 9 P. M.
on the date above stated. (Born alive or stillborn)

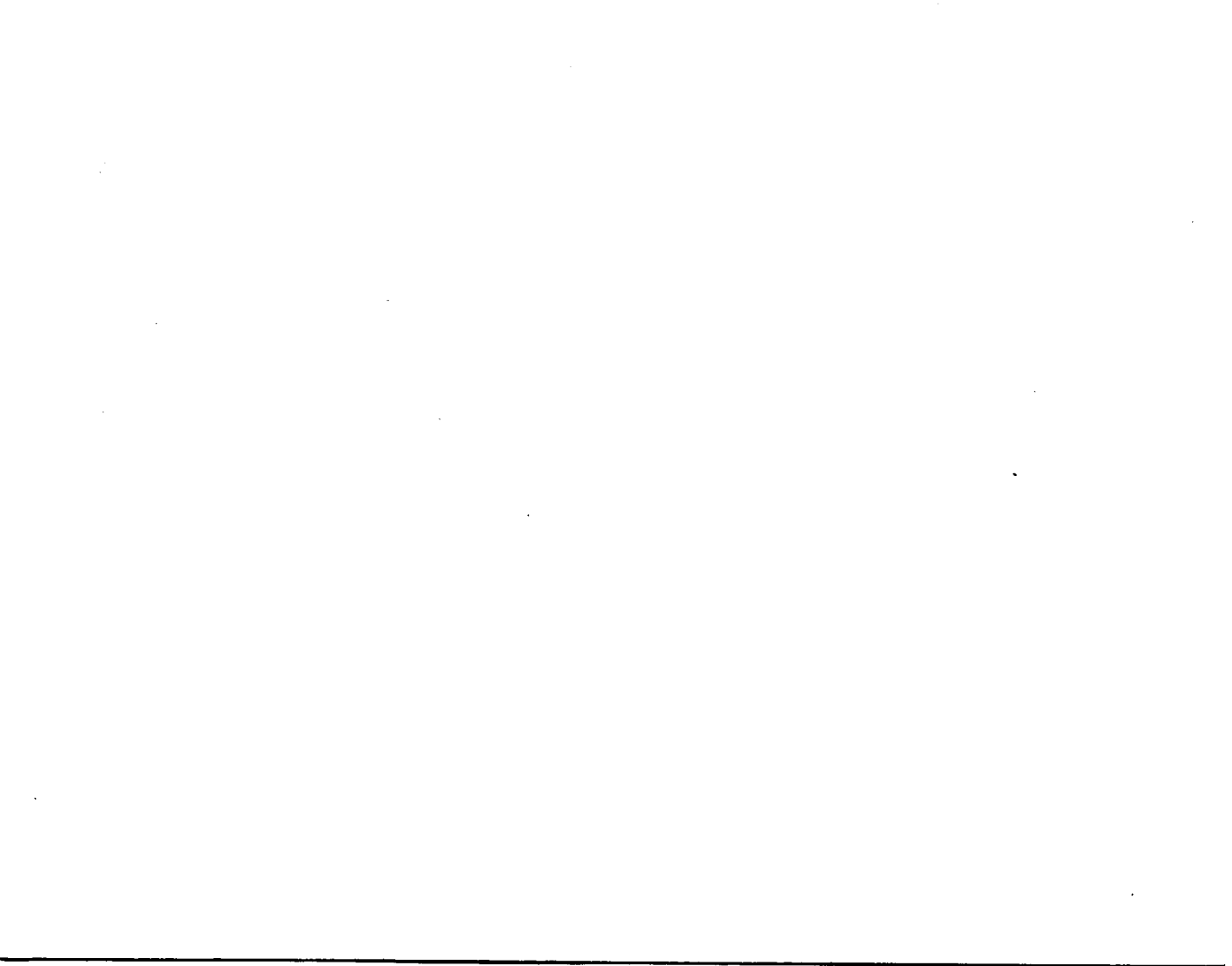
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Russell Tiger

(Physician or midwife)

Give names added from a supplemental report.
Ellis K. and — 19—
Registrar.

Address Sada Spgs.
Filed Feb 29 1924 Ellis K. and
Registrar.



815-229012814
PLACE OF BIRTH

RECEIVED

MAR 4 1924

BUREAU OF VITAL
STATISTICSSTATE OF IDAHO
BUREAU OF VITAL STATISTICS

V. S. No. 11-C-25m-1-1-18

County of Butte

City of Moore

Registration District No.

76

11

File No.

S 119664

214

No.

St.

Primary Registration District No.

2153

Registered No.

Hospital

FULL NAME OF CHILD

Donna Maxine Haney

Sex of Child

Female

Twin
Triplet
or other?

and

Number
in order
of birthLegiti-
mate?

Yes

Date of
Birth

12-22-23

1923
(Month) (Day) (Year)

FULL NAME

FATHER
Kerned C Haney

RESIDENCE

Moore

COLOR

W

AGE AT LAST
BIRTHDAY26
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Teacher

FULL MAIDEN NAME

MOTHER
Riegland, Miss Hannah

RESIDENCE

Moore

COLOR

W

AGE AT LAST
BIRTHDAY23
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Hom

Number of child of this mother, including present birth

1

Number of children of this mother now living, including present birth

1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.Still born
(Born alive or stillborn)

at 4 P

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Carroll A. Jensen

(Physician or midwife)

Given names added from a supplemental report.

Address

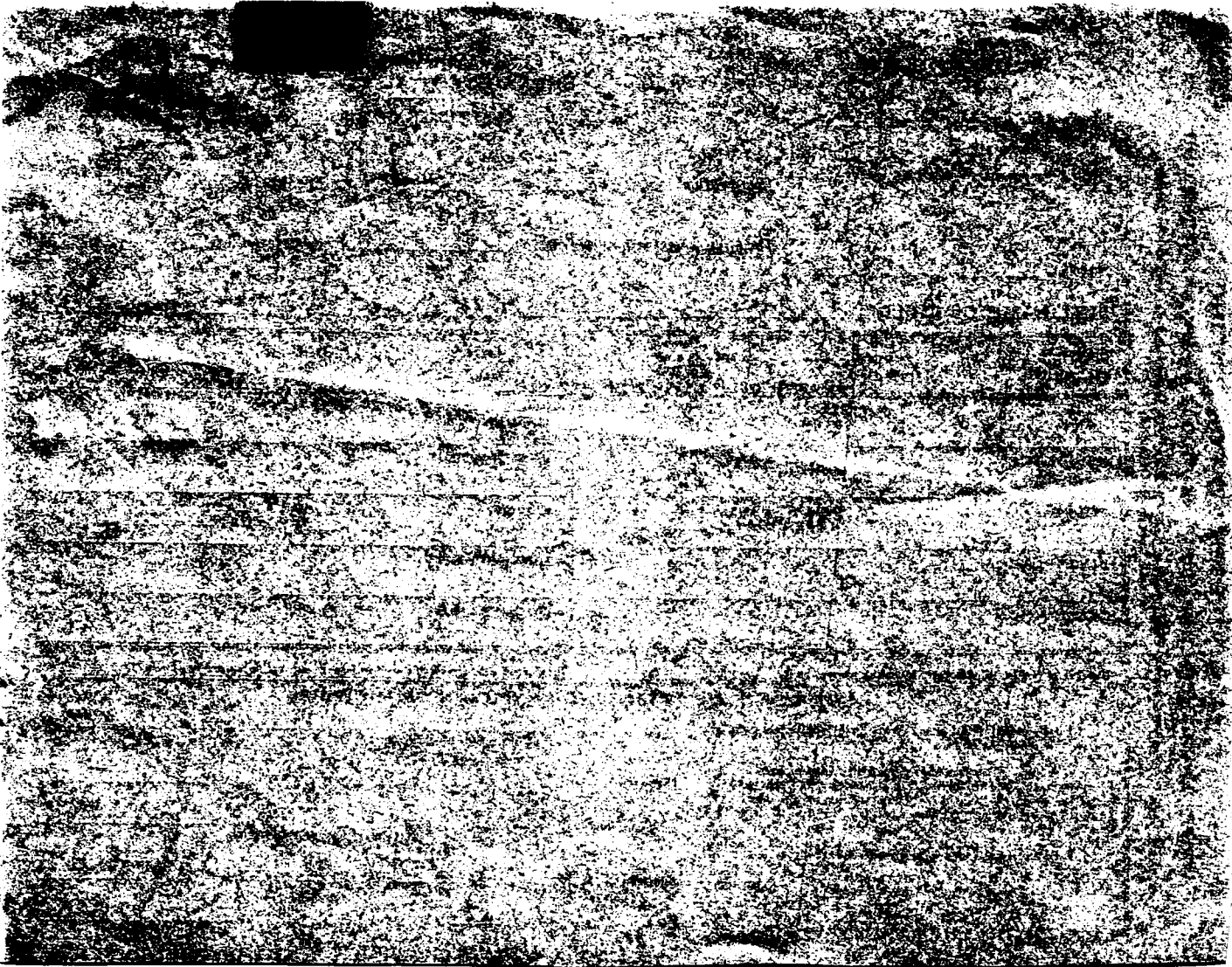
Moore - Idaho

Filed

2/29/24

Rae Nawacki

Registrar



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

795 229 028-867

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S

County of Kootenai

City of C. L. O. C.

No. Kill Island St.

Hospital C. L. O. C.

Registration District No. 30

File No. 119758

Primary Registration District No. 1001

Registered No. 1712

FULL NAME OF CHILD Grace Greenfield

Sex of Child <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth <u>5</u>	Legiti mate? <u>yo</u>	Date of Birth <u>12 29 28</u> (Month) (Day) (Year)
-----------------------	---	-----	--	------------------------------	---

FATHER
FULL NAME Charles Greenfield
RESIDENCE C. L. O. C. R. F. D.
COLOR white AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Missouri
OCCUPATION Millman

MOTHER
FULL MAIDEN NAME Lauri Helen Hogan
RESIDENCE C. L. O. C. R. F. D.
COLOR white AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Fargo N. Dak
OCCUPATION Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 12. P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr Wood

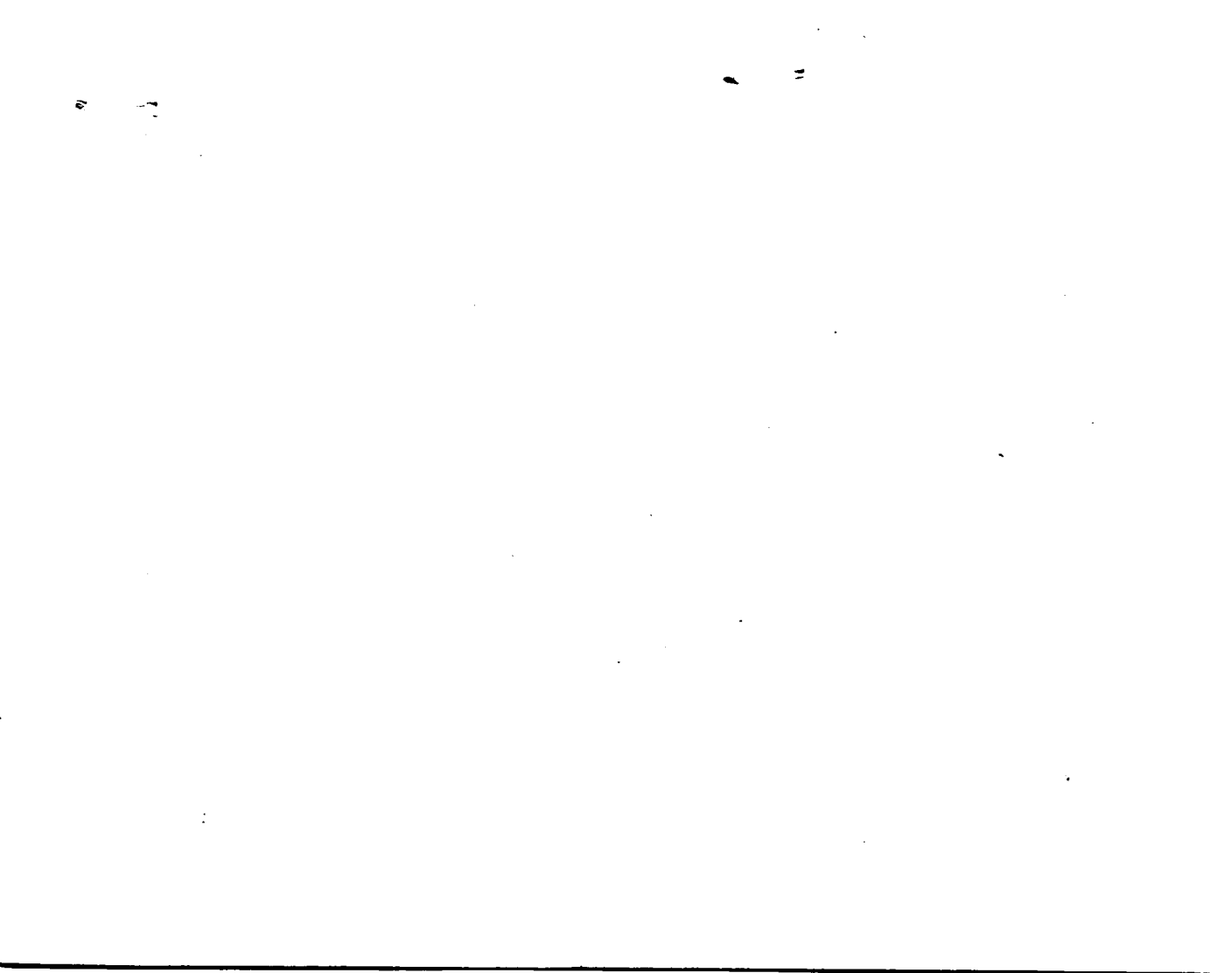
(Physician or midwife)

Given names added from a supplemental report.

Address Greenfield

Filed Jan 4 1929 D. D. Green
Registrar

Registrar



1.

PLACE OF DEATH

County of *Kootenai*City of *Coeur d'Alene*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *32*Primary Registration District No. *1051*

(No.)

(St.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. *44132*Local Registrar's No. *1295*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word)

6. DATE OF BIRTH

*12**29**1923*

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day how many
0 hrs. or
0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

Chas. Greenfield

11. BIRTHPLACE

OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME

OF MOTHER

Laura Hagen

13. BIRTHPLACE

OF MOTHER

(State or Country)

N.D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Greenfield

(Address)

15.

Filed

*Jan 4**1923**D.D. Prema*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Dec.**29**1923*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Dec. 29**1923*to *Dec. 29**1923*that I last saw him alive on *Still born*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Uremic poisoning in mother. (Puerperal).

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Dec. 31/1923

(Address)

Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Forest Cem. Coeur d'Alene**12-31 1923*

20. UNDERTAKER

ADDRESS

*Carney**Coeur d'Alene*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis**, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

249-160-028-553
PLACE OF BIRTH

RECEIVED
MAY 2 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho
City of Idaho
No. _____ St. Registration District No. 145 State File No. 121377

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD not named still born
(Certificate of no value without full name of child)

Sex of Child M Twin Triplet or other? 1 and { Number in order of birth } Legiti- mate? yes Date of birth 10-10-1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth		Number of child of this mother now living, including present birth	
FULL NAME	FATHER <u>Frank O Burroughs</u>	FULL MAIDEN NAME	MOTHER <u>Gladys Nelson</u>
RESIDENCE	<u>Bay View Ida</u>	RESIDENCE	<u>Bay View Ida</u>
COLOR	<u>Wh.</u>	COLOR	<u>Wh.</u>
AGE AT LAST BIRTHDAY	<u>23</u> (Years)	AGE AT LAST BIRTHDAY	<u>20</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Minn -</u>
OCCUPATION	<u>Lab</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 12.05 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) Earl A. Smith M.D.
(Physician or midwife)

Address _____
Filed 10/19 1923 G. K. Smith
Registrar. Registrar.

10/10

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

113-115-
003-113

DEPARTMENT OF COMMERCE—BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF BIRTH

State File No. 1923
Registered No. 6

1. PLACE OF BIRTH—
County Id. Hall Reservation State Idaho 122539
Township _____ or Village _____
City _____ No. _____ St. _____ Ward _____
(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child Henry Jackson (If child is not yet named, make supplemental report, as directed)

3. Sex of child <u>Male</u>	To be answered ONLY in event of plural births.	4. Twin, triplet or other _____ 5. Number, in order of birth _____	6. Legitimate? <u>yes</u>	7. Date of birth <u>Dec 15 1923</u> (Month, day, year)
--------------------------------	--	---	---------------------------	---

8. Full name of FATHER <u>Peter Jackson</u>	14. Full maiden name of MOTHER <u>Nellie Jackson</u>
9. Residence (Usual place of abode) <u>Id. Hall Reservation</u> If nonresident, give place and State	15. Residence (Usual place of abode) <u>Id. Hall Reservation</u> If nonresident, give place and State
10. Color or race <u>Ind 4/4</u>	16. Color or race <u>Ind 4/4</u>
11. Age at last birthday <u>28</u> (Years)	17. Age at last birthday <u>23</u> (Years)
12. Birthplace (city or place) <u>Idaho</u> (State or country)	18. Birthplace (city or place) <u>Id. Hall Reservation</u> (State or country)
19. Occupation <u>Farming</u> Nature of industry	19. Occupation <u>Housewife</u> Nature of industry

20. Number of children of this mother
(Taken as of time of birth of child herein certified and including this child.)
(a) Born alive and now living 2 (b) Born alive but now dead 1 (c) Stillborn 1

No doctor attending

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
I hereby certify that I attended the birth of this child, who was born dead at 11 P. m. on the date above stated.
(Born alive or stillborn)

Signature Henry A. Mueller

(Physician or Midwife)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given name added from a supplemental report _____
(Month, day, year)

Address Id. Hall Idaho
Filed 11-20-1923


Registrar. _____

SECRET

[illegible]

12. Resident (Total of 1000)
11 non-Indians give place and date

[illegible]

<p>  Ministry of Industry and Commerce Republic of Turkey </p>	<p> Ministry of Industry and Commerce Republic of Turkey </p>
--	--

(a) Great wall was built with mud (b) Great wall was built with mud (c) Great wall was built with mud

1. I hereby certify that I attended the birth of this child, who was _____ is _____ on the date above stated.

21 August 1954

1967
 1968
 1969
 1970
 1971
 1972
 1973
 1974
 1975
 1976
 1977
 1978
 1979
 1980
 1981
 1982
 1983
 1984
 1985
 1986
 1987
 1988
 1989
 1990
 1991
 1992
 1993
 1994
 1995
 1996
 1997
 1998
 1999
 2000
 2001
 2002
 2003
 2004
 2005
 2006
 2007
 2008
 2009
 2010
 2011
 2012
 2013
 2014
 2015
 2016
 2017
 2018
 2019
 2020
 2021
 2022
 2023
 2024
 2025
 2026
 2027
 2028
 2029
 2030
 2031
 2032
 2033
 2034
 2035
 2036
 2037
 2038
 2039
 2040
 2041
 2042
 2043
 2044
 2045
 2046
 2047
 2048
 2049
 2050
 2051
 2052
 2053
 2054
 2055
 2056
 2057
 2058
 2059
 2060
 2061
 2062
 2063
 2064
 2065
 2066
 2067
 2068
 2069
 2070
 2071
 2072
 2073
 2074
 2075
 2076
 2077
 2078
 2079
 2080
 2081
 2082
 2083
 2084
 2085
 2086
 2087
 2088
 2089
 2090
 2091
 2092
 2093
 2094
 2095
 2096
 2097
 2098
 2099
 2100
 2101
 2102
 2103
 2104
 2105
 2106
 2107
 2108
 2109
 2110
 2111
 2112
 2113
 2114
 2115
 2116
 2117
 2118
 2119
 2120
 2121
 2122
 2123
 2124
 2125
 2126
 2127
 2128
 2129
 2130
 2131
 2132
 2133
 2134
 2135
 2136
 2137
 2138
 2139
 2140
 2141
 2142
 2143
 2144
 2145
 2146
 2147
 2148
 2149
 2150
 2151
 2152
 2153
 2154
 2155
 2156
 2157
 2158
 2159
 2160
 2161
 2162
 2163
 2164
 2165
 2166
 2167
 2168
 2169
 2170
 2171
 2172
 2173
 2174
 2175
 2176
 2177
 2178
 2179
 2180
 2181
 2182
 2183
 2184
 2185
 2186
 2187
 2188
 2189
 2190
 2191
 2192
 2193
 2194
 2195
 2196
 2197
 2198
 2199
 2200
 2201
 2202
 2203
 2204
 2205
 2206
 2207
 2208
 2209
 2210
 2211
 2212
 2213
 2214
 2215
 2216
 2217
 2218
 2219
 2220
 2221
 2222
 2223
 2224
 2225
 2226
 2227
 2228
 2229
 2230
 2231
 2232
 2233
 2234
 2235
 2236
 2237
 2238
 2239
 2240
 2241
 2242
 2243
 2244
 2245
 2246
 2247
 2248
 2249
 2250
 2251
 2252
 2253
 2254
 2255
 2256
 2257
 2258
 2259
 2260
 2261
 2262
 2263
 2264
 2265
 2266
 2267
 2268
 2269
 2270
 2271
 2272
 2273
 2274
 2275
 2276
 2277
 2278
 2279
 2280
 2281
 2282
 2283
 2284
 2285
 2286
 2287
 2288
 2289
 2290
 2291
 2292
 2293
 2294
 2295
 2296
 2297
 2298
 2299
 2300
 2301
 2302
 2303
 2304
 2305
 2306
 2307
 2308
 2309
 2310
 2311
 2312
 2313
 2314
 2315
 2316
 2317
 2318
 2319
 2320
 2321
 2322
 2323
 2324
 2325
 2326
 2327
 2328
 2329
 2330
 2331
 2332
 2333
 2334
 2335
 2336
 2337
 2338
 2339
 2340
 2341
 2342
 2343
 2344
 2345
 2346
 2347
 2348
 2349
 2350
 2351
 2352
 2353
 2354
 2355
 2356
 2357
 2358
 2359
 2360
 2361
 2362
 2363
 2364
 2365
 2366
 2367
 2368
 2369
 2370
 2371
 2372
 2373
 2374
 2375
 2376
 2377
 2378
 2379
 2380
 2381
 2382
 2383
 2384
 2385
 2386
 2387
 2388
 2389
 2390
 2391
 2392
 2393
 2394
 2395
 2396
 2397
 2398
 2399
 2400
 2401
 2402
 2403
 2404
 2405
 2406
 2407
 2408
 2409
 2410
 2411
 2412
 2413
 2414
 2415
 2416
 2417
 2418
 2419
 2420
 2421

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

Current Complete December 1923
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Let. Hall Reservation State Idaho Registered No. 46961
Township _____ or Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Herbert Jackson
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Ind 4/4 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) Dec 15 - 1923
7 AGE Years _____ Months _____ Days _____
If LESS than 1 day, --- hrs. or --- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Let. Hall Reservation

PARENTS

10 NAME OF FATHER Peter Jackson

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Nellie Jackson

13 BIRTHPLACE OF MOTHER (city or town) Let. Hall Reservation
(State or country)

14

Informant Peter Jackson
(Address) Let. Hall, Idaho

15

Filed Sept 8, 1924 F. W. Almond, M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1923

17. by doctor attending
I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Stillborn at term - due to
breach presentation and pressure
on cord.

_____, 19____, (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY

(SECONDARY)

_____, 19____, (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. Miller, M. D.

, 19____ (Address) Let. Hall, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Let. Hall Reservation Dec 15 1923

20 UNDERTAKER

ADDRESS

Peter Jackson Let. Hall, Idaho

UNITED STATES STANDARD CERTIFICATE OF DEATH

As by U. S. Census and American Public Health Association

statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Chief engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Dray laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

41320-0-1947 366
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 126612

County of Booneville

City of Ida Falls

No. 73 Registration District No. 214-0 State File No. 347

Hospital Stillborn Local Registrar's No. 347

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 10-1/23 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Oscar A Mathews
RESIDENCE Ida Falls, Ida
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE ?
OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Ruth Coffin
RESIDENCE Ida Falls, Ida
COLOR white AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Ida Falls, Ida
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5: A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. C. Freester

m. d.
(Physician or midwife)

Address Ida Falls, Ida

Filed Oct 14 1928 W. J. Fennell

Registrar.

Registrar.

10/11/23, 1928

STATISTICS, LATE TO

CONFIDENTIAL

NOV 21 1964

11-11-61

(Indicate if no value without full name of (b)(6))

Page 1 (b) (7) (D)



10-11-51
 10-12-51
 10-13-51
 10-14-51
 10-15-51
 10-16-51
 10-17-51
 10-18-51
 10-19-51
 10-20-51
 10-21-51
 10-22-51
 10-23-51
 10-24-51
 10-25-51
 10-26-51
 10-27-51
 10-28-51
 10-29-51
 10-30-51
 10-31-51
 11-1-51
 11-2-51
 11-3-51
 11-4-51
 11-5-51
 11-6-51
 11-7-51
 11-8-51
 11-9-51
 11-10-51
 11-11-51
 11-12-51
 11-13-51
 11-14-51
 11-15-51
 11-16-51
 11-17-51
 11-18-51
 11-19-51
 11-20-51
 11-21-51
 11-22-51
 11-23-51
 11-24-51
 11-25-51
 11-26-51
 11-27-51
 11-28-51
 11-29-51
 11-30-51
 12-1-51
 12-2-51
 12-3-51
 12-4-51
 12-5-51
 12-6-51
 12-7-51
 12-8-51
 12-9-51
 12-10-51
 12-11-51
 12-12-51
 12-13-51
 12-14-51
 12-15-51
 12-16-51
 12-17-51
 12-18-51
 12-19-51
 12-20-51
 12-21-51
 12-22-51
 12-23-51
 12-24-51
 12-25-51
 12-26-51
 12-27-51
 12-28-51
 12-29-51
 12-30-51
 12-31-51
 1-1-52
 1-2-52
 1-3-52
 1-4-52
 1-5-52
 1-6-52
 1-7-52
 1-8-52
 1-9-52
 1-10-52
 1-11-52
 1-12-52
 1-13-52
 1-14-52
 1-15-52
 1-16-52
 1-17-52
 1-18-52
 1-19-52
 1-20-52
 1-21-52
 1-22-52
 1-23-52
 1-24-52
 1-25-52
 1-26-52
 1-27-52
 1-28-52
 1-29-52
 1-30-52
 1-31-52
 2-1-52
 2-2-52
 2-3-52
 2-4-52
 2-5-52
 2-6-52
 2-7-52
 2-8-52
 2-9-52
 2-10-52
 2-11-52
 2-12-52
 2-13-52
 2-14-52
 2-15-52
 2-16-52
 2-17-52
 2-18-52
 2-19-52
 2-20-52
 2-21-52
 2-22-52
 2-23-52
 2-24-52
 2-25-52
 2-26-52
 2-27-52
 2-28-52
 2-29-52
 2-30-52
 3-1-52
 3-2-52
 3-3-52
 3-4-52
 3-5-52
 3-6-52
 3-7-52
 3-8-52
 3-9-52
 3-10-52
 3-11-52
 3-12-52
 3-13-52
 3-14-52
 3-15-52
 3-16-52
 3-17-52
 3-18-52
 3-19-52
 3-20-52
 3-21-52
 3-22-52
 3-23-52
 3-24-52
 3-25-52
 3-26-52
 3-27-52
 3-28-52
 3-29-52
 3-30-52
 3-31-52
 4-1-52
 4-2-52
 4-3-52
 4-4-52
 4-5-52
 4-6-52
 4-7-52
 4-8-52
 4-9-52
 4-10-52
 4-11-52
 4-12-52
 4-13-52
 4-14-52
 4-15-52
 4-16-52
 4-17-52
 4-18-52
 4-19-52
 4-20-52
 4-21-52
 4-22-52
 4-23-52
 4-24-52
 4-25-52
 4-26-52
 4-27-52
 4-28-52
 4-29-52
 4-30-52
 5-1-52
 5-2-52
 5-3-52
 5-4-52
 5-5-52
 5-6-52
 5-7-52
 5-8-52
 5-9-52
 5-10-52
 5-11-52
 5-12-52
 5-13-52
 5-14-52
 5-15-52
 5-16-52
 5-17-52
 5-18-52
 5-19-52
 5-20-52
 5-21-52
 5-22-52
 5-23-52
 5-24-52
 5-25-52
 5-26-52
 5-27-52
 5-28-52
 5-29-52
 5-30-52
 5-31-52
 6-1-52
 6-2-52
 6-3-52
 6-4-52
 6-5-52
 6-6-52
 6-7-52
 6-8-52
 6-9-52
 6-10-52
 6-11-52
 6-12-52
 6-13-52
 6-14-52
 6-15-52
 6-16-52
 6-17-52
 6-18-52
 6-19-52
 6-20-52
 6-21-52
 6-22-52
 6-23-52
 6-24-52
 6-25-52
 6-26-52
 6-27-52
 6-28-52
 6-29-52
 6-30-52
 7-1-52
 7-2-52
 7-3-52
 7-4-52
 7-5-52
 7-6-52
 7-7-52
 7-8-52
 7-9-52
 7-10-52
 7-11-52
 7-12-52
 7-13-52
 7-14-52
 7-15-52
 7-16-52
 7-17-52
 7-18-52
 7-19-52
 7-20-52
 7-21-52
 7-22-52
 7-23-52
 7-24-52
 7-25-52
 7-26-52
 7-27-52
 7-28-52
 7-29-52
 7-30-52
 7-31-52
 8-1-52
 8-2-52
 8-3-52
 8-4-52
 8-5-52
 8-6-52
 8-7-52
 8-8-52
 8-9-52
 8-10-52
 8-11-52
 8-12-52
 8-13-52
 8-14-52
 8-15-52
 8-16-52
 8-17-52
 8-18-52
 8-19-52
 8-20-52
 8-21-52
 8-22-52
 8-23-52
 8-24-52
 8-25-52
 8-26-52
 8-27-52
 8-28-52
 8-29-52
 8-30-52
 8-31-52
 9-1-52
 9-2-52
 9-3-52
 9-4-52
 9-5-52
 9-6-52
 9-7-52
 9-8-52
 9-9-52
 9-10-52
 9-11-52
 9-12-52
 9-13-52
 9-14-52
 9-15-52
 9-16

There are two main methods of collecting data:

Number of copies of this material now held:

POSITION

SECRET

馬六甲海峽海峽海峽海峽

COLO

● 2. 2. 2 電圧降下損失

NOTES:

References

Abstract

TRA-LTA BOA
YACHIMO

1997

1990

STATEMENT OF A WITNESS OR MEDICAL

RECEIVED

6710 1-000121

1. The first step is to identify the problem or goal. This involves understanding the current situation and what needs to be achieved. It is important to be clear and specific about the objectives.

金銀器

1

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bannock*
City of *Idaho Falls*

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *73*
BUREAU OF STATISTICS
Registration District No. *211-0*
St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *43724*
Local Registrar's No. *91*

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female *White*

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Infant
(Write the word)

6. DATE OF BIRTH

Oct *1* *1923*
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds. IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF
Father

Oscar Mathews

11. BIRTHPLACE

FATHER

(State or Country) *?*

12. MAIDEN NAME
OF MOTHER

Ruth Coffin

13. BIRTHPLACE
OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Beris Payne*
(Address) *City RD 1*

15.

Filed *Oct 2* 19 *23* *Idaho Falls*
Local Registrar *Hollister*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct *1* *1923*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
10/1 *1923*, to *10/1* *1923*,

that I last saw h..... alive on..... 19.....,
and that death occurred on the date stated above, at *5 A.M.*

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19..... (Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death..... yrs. mos. days, State..... yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls DATE OF BURIAL *10-2-1923*

20. UNDERTAKER

B. B. Woodward ADDRESS *Idaho Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

442-109.008-613
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock **RECEIVED**
City of Idaho Falls, Ida. DEC 10 1924 **CERTIFICATE OF BIRTH**
No. _____ St. 73 **STATISTICS**
Hospital _____ Primary Registration District No. 210 File No. _____
Registered No. 362
FULL NAME OF CHILD Shelton
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and }	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>3/9/23</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including (present birth) _____

FULL NAME <u>Geo. Thos. Thuesgrane</u>	FATHER	FULL MAIDEN NAME <u>Violet Walker</u>	MOTHER
RESIDENCE <u>Idaho Falls, Ida.</u>		RESIDENCE <u>Idaho Falls, Ida.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Menan, Ida.</u>		BIRTHPLACE <u>Lansville, Ida.</u>	
OCCUPATION <u>R.P. man</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Shelton at _____ M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

_____, 19____

Registrar.

(Signature) T. H. Hallerstein

Address Idaho Falls, Ida.

Filed Oct 14 1924 4 W. H. H. H.
Registrar.

FILE # 136042

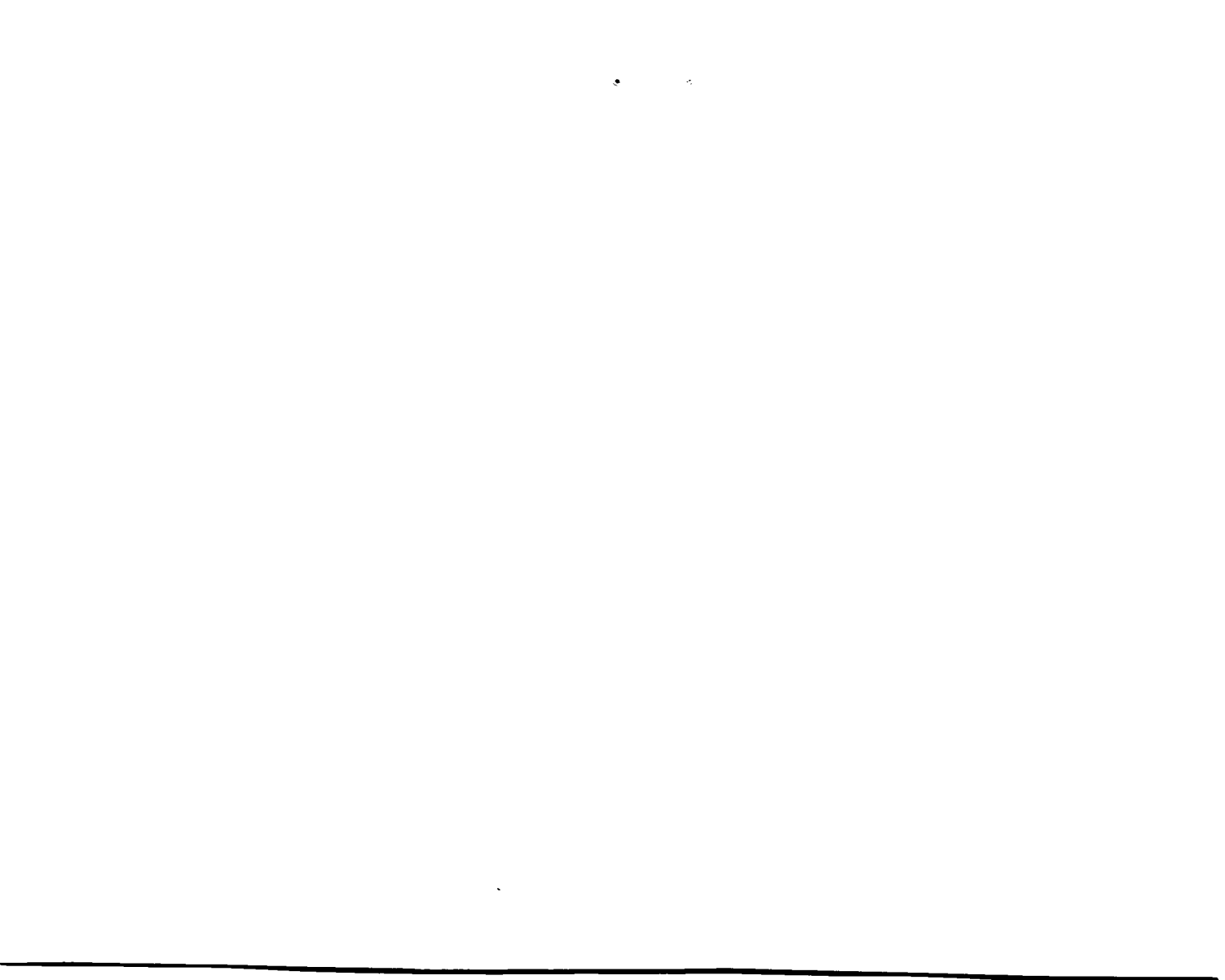
YEAR 1923

IDAHO STILLBIRTH CERTIFICATE



VOID DUP OF 1923-116011

STILLBIRTH



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

386-221-014-751
PLACE OF BIRTH

RECEIVED MAR 2 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon

City of Nampa

CERTIFICATE OF BIRTH

No. St. Registration District No. State File No. 149490

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD Rosegina Thomas

(Certificate of no value without full name of child)

Sex of Child <u>♀</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 21</u> 192 <u>3</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth Number of child of this mother now living, including present birth

FULL NAME <u>Rose Thomas</u>	FATHER
RESIDENCE <u>Nampa</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>41</u> (Years)
BIRTHPLACE <u>Malad Idaho</u>	
OCCUPATION <u>Laborer</u>	

FULL MAIDEN NAME <u>Zena Peabody</u>	MOTHER
RESIDENCE <u>Nampa</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Malad Idaho</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Born alive } at M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Mrs Rha C Thompson

(Physician or midwife)

Address Nampa Idaho R. D. 1

Filed Mar 2 1927 David Bunell
State Registrar.

Registrar.

110